NEW PATIENT INFORMATION

Today's Date:			Home Phone Number:
Patient Name: (Last, First, M.I.)			Cell Phone Number:
Street Address		City, State, Zip Code	
Social Security Number / /	Date of Birth / /	Sex M F	Marital Status S M D W
Current Employer	Address		Work Phone Number:
Spouse's Name	Spouse's Date of Birth		Spouse's Work Phone:
Local Contact (not living with you)	Street Address	City, State, Zip Code	
Relationship to you	Work # ( )	Home# ( )	
Referred By:			

RESPONSIBLE PARTY FOR PAYMENT IF OTHER THAN PATIENT

Name (Last, First, M.I.)		Home Phone Number: ( )
Street Address:		City, State, Zip Code
Social Security Number / /	Date of Birth / /	Sex M F
Current Employer	Address	Work Phone Number:

Please list current and former doctors:			
Doctor	Specialty	Doctor	Specialty

I hereby assign to Medical Specialists Associated any money payable to me under hospitalization or other insurance coverage, and/or other arrangements with third parties, for payment of such services. I also authorize Medical Specialists to furnish my insurance company the medical information requested. I also agree to be responsible for any testing or treatment that may not be considered by my insurance company, to be medically necessary.

Signature: _____ Date: _____

Medical Specialists Associated
5461 La Sierra Drive
Dallas, Texas 75231

In signing this HIPAA Patient Acknowledgment form, you acknowledge and authorize, that you hold harmless this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring from this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this Healthcare Facility is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given the opportunity to ask question; that I have received a copy of the signed authorization; that I may inspect a copy of my PHI to be used or disclosed under this authorization; that this Healthcare Facility has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization. A copy of this signed, dated Authorization shall be as effective as the original.

Consent to release Protected Health Information (PHI)

I understand that in order to disclose my PHI, Medical Specialist Associated, must have my consent, therefore, I authorize Medical Specialist Associated to disclose my PHI as described in the above forms, to the recipients listed below.

Description of the information to be disclosed (check all that apply)

☐ All Procedures ☐ Test Results ☐ Appointments ☐ Other ☐ Surgeries ☐ Billing/Account Information

Name(s) of the person(s) authorized to obtain the above mentioned information. (e.g. Physician other than referring doctor, family members and other specified person/persons)

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Contact Information:

I authorize Medical Specialists Associated, to contact me at the following with results or questions:

Home: _____ Cell: _____ Work: _____

Email: _____

May we leave a detailed message on your answering machine or voicemail?

Yes ☐ No ☐ Failure to check one of these boxes may delay results

By Patient: (Print Name) _____ DOB: _____

(Signature) _____

Date: _____

Or Patient's Representative (Print Name, sign and describe authority)

_____ Date: _____

MEDICAL SPECIALISTS ASSOCIATED

PATIENT HISTORY FORM

Note: This is a confidential record amd will be kept in your doctor's office, information obtained here will not be released to anyone witho your authorization to do so.

Today's Date: _____/_____/_____

Last Name: _____

Social Security No. : _____

Occupation: _____

Pharmacy Name : _____

Date of Last Physical Exam_____/_____/_____

First Name: _____

Date of Birth _____/_____/_____

Marital Status: Married □ Single □ Divorced□ Widowed□

Pharmacy Phone No: _____

Current prescription medications: □ None

Name of Drug	Mg Dose	# tablets	# times per day

Additional current prescription medications:

Name of Drug	Mg Dose	# tablets	# times per day

Past Medical, Family & Social History

List any personal past illness and/or Surgeries and when they occurred.

Illness or Surgery	Date

List all serious illnesses in your immediate family.(Ex: diabetes,tuberculosis, breast cancer, heart disease, etc)

Illness	Relationship

Last Mammogram _____ Last PAP _____

Last PSA or Prostate Exam _____

Are you on a special diet? □Yes □No (If yes, please explain)

_____

_____

Do you have any drug/medicine allergies? □Yes □No (If yes,please explain)

_____

_____

Substance Abuse?□Yes □No

Advanced Directive/ Living Will: □Yes □No

Tattoos: □Yes □No

Do you smoke? □Yes □No

If yes, how much?_____

Do you Drink? □Yes □No

If yes, how much?_____

Do you exercise regularly? □Yes □No

If yes, how much? _____

Immunizations:Flu ____/____/_____ Pneu _____/____/____ Tetanus ____/____/_____ Other ____/____/_____

Physician use only: (Comments/Notes)

Physician/Provider Signature: _____ Date:_____