Dallas Medical

Vijaya Mummadi, M.D.

Doctors of Internal Medicine 9900 N Central Expwy, Ste 225,(Glen Lakes Bldg) Dallas, TX 75231, Phone 469-646-8880, Fax: 469-646-8884

PATIENT INFORMATION:

Please print clearly and fill out completely: **Primary Care Physician__________________Referred By____________________**

Name____
First Middle Last

Address____
Street Apt City State Zip

Home Phone (___)________________Work Phone (___)______________Mobile (___)______________Beeper (___)________________

Date of Birth___/___/_____Age_____Social Security#____________________Driver License__________________State__________

Name of Employer____Phone# (___)____________

Address____City______________________State_____________

Martial Status__________Spouse/Significant Other's Name_____________________________________Date of Birth___/___/____

Primary Insurance Information

Name of Insurance____

Insurance Address for Claims____City_________________State____Zip________

Name of Insured____Relationship to Patient______________________________

Insured's Information:

Date of Birth___/___/______Insured's Social Security#______________________Member#_______________Group#___________

Insured's Employer____Phone# (___)__________________

Insured's Employer Address______________________________________City___________________State______Zip________

Secondary Insurance Information

Name of Insurance____

Insurance Address for Claims____City_________________State____Zip________

Name of Insured____Relationship to Patient______________________________

Insured's Information:

Date of Birth___/___/______Insured's Social Security#______________________Member#_______________Group#___________

Insured's Employer____Phone# (___)__________________

Insured's Employer Address______________________________________City___________________State______Zip______

Nearest Friend or Relative Not Living With You (in case of emergency)

Name____Relationship to Patient________________

Address____City_______________________State Zip______________

Home Phone (___)___________Business Phone(___)________________Mobile(___)_______________Beeper(_)_______________

I hereby assign to Dallas Medical any money payable to me under hospitalization or other insurance coverage, and/or arrangements with their parties, for payment of such services. I authorize Dallas Medical to furnish my insurance company the medical information requested. I agree to be responsible for any testing or treatment that may not be considered by my insurance company, to be medically necessary. <u>I also agree to pay Dallas Medical $60.00 for no show appointments if not properly cancelled within 24 hours prior to the scheduled appointment</u>.

Signature____Date___/___/_____Account# ____________________________

Dallas Medical **Vijaya Mummadi, M.D., Rachel Jaison, FNP**
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NEW PATIENT HISTORY FORM

Name: ___________________________________ **DOB:** __________

Social History

Smoking/Tobacco use: Yes/No Number of packs per day: ____ [ ] Quit When? _____ Never Smoked _____

Number of alcoholic drinks/day on average: _____ Number of caffeinated drinks/day on average: _____

Drug abuse: Yes/ No

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Partnered

Occupation: _______________________

Residence: circle one: Home / Apartment / Assisted Living / Long Term Care / Memory Care

Do you exercise regularly? Yes/No Type(s) of activity: _____________________ Hours per week: _____

Memory impairment	Yes/No		
Hearing impairment	Yes/No	Hearing Aid	Yes/No
Snoring	Yes/No	Daytime sleepiness	Yes/No
Falls	Yes/No	Number of fall in 1 year: _____	
Do You Drive	Yes/No	Vision impairment	Yes/No

Living will/Advance directives Yes/No
Medical Power of Attorney Yes/No If yes: Name and contact information _______________________
DNR (Do not resuscitate) Yes/No

Have you ever received a blood transfusion?	Yes/No	Do you have any tattoos?	Yes/No
Do you have a carbon monoxide detector?	Yes/No	Do you wear a seat-belt?	Yes/No

Sexual Health History

Sexual partners: Male [ ] Female [ ] Sexually transmitted infections: _______________________

Preventive Health History

Date of last bone density scan: __________
Date of last skin exam: __________
Date of last cardiac stress test: __________
Diabetic foot exam: _________

Date of last eye exam/diabetic eye exam: __________
Date of last dental exam: __________
Colorectal cancer screening: [ ] colonoscopy _____
[ ] stool for occult _____

Immunizations:

[ ] Flu Vaccine Date: __________
[ ] Pneumonia Vaccine Date: __________
[ ] Tetanus Vaccine Date: __________
[ ] Shingles Vaccine
[ ] Cervical Cancer Vaccine
[ ] Hepatitis B Vaccine

Women:

Number of pregnancies: ___
Date of last PAP smear: _________
Date of last mammogram: __________
Do you perform regular self-breast exams? [ ] Yes [ ] No
Number of miscarriages: ___
Have you had an abnormal PAP smear? [ ] Yes [ ] No
Have you had an abnormal mammogram? [ ] Yes [ ] No

Men:

Date of last rectal exam: ________
Date of last PSA: _________
Have you had as abnormal PSA level? [ ] Yes [ ] No
Do you perform regular self-testicular exams? [ ] Yes [ ] No

Referred by: __ Google, __ Zocdoc, __ Friend _______________, __ Dr. _______________,

Patient Signature: ______________________________________ Date: __________

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NEW PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Name:____________________________________ **DOB:** ___________

Medical History

ALL medications and supplements taken regularly: [ ] Separate list attached

Drug Name	Dose	# Times / day	Drug Name	Dose	# Times / day

Allergies to medications: [ ] No known drug allergies [ ] Separate list attached

Drug	Reaction	Drug	Reaction

Previous surgeries: [ ] Separate list attached

Date	Type of surgery	Date	Type of surgery

Previous hospitalizations *not including* surgeries [ ] Separate list attached

Date	Reason	Date	Reason

All medical problems: [ ] Separate list attached

Date	Problem	Date	Problem	Date	Problem

Family History

History of disease in family (blood relatives only):

Disease	Relation	Age diagnosed	Disease	Relation	Age diagnosed
[ ] Colon Cancer			[ ] Diabetes		
[ ] Breast Cancer			[ ] Heart Disease		
[ ] Ovarian Cancer			[ ] Stroke		
[ ] Prostate Cancer			[ ] High Cholesterol		
[ ] High Blood Pressure			[ ] Other		

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CONSENT FOR TREATMENT

I voluntarily consent to such medical or surgical procedures, care, or treatments by my physician as are deemed necessary for me in her professional judgment. I also consent to the same with regard to her assistants' or designees' services rendered under her general or specific instructions.

I also acknowledge that the practice of medicine is an inexact science and that no guarantees can be made to me with regard to results of diagnostic or therapeutic examinations, evaluations, procedures, or treatments.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical insurance benefits to Dallas Medical for services rendered by the physician in person or by her assistants under her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

I also understand that all laboratory tests, radiology and diagnostic procedures, or other pathology exams ordered by my physician will be sent to outside facilities and could be billed separately by these facilities. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Dallas Medical to release any medical or incidental information that may be necessary for my medical care or for processing applications for insurance benefits.

MEDICARE/MEDICAID

I certify that the information given by me in applying for payment is current. I authorize release of all records on request of the authorized relevant government agency. I request that direct payment of authorized benefits be made to Dallas Medical on my behalf.

A photocopy of these assignments shall be as valid as the original.

PATIENT'S PRINTED NAME:____DATE: ___________________

PATIENT'S SIGNATURE:____DOB: ___________________

PARENT/GUARDIAN NAME: (If required) ____

PARENT/GUARDIAN SIGNATURE: (if required) ____

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In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to you family, friends, and coworkers.

Please circle your response to the following:

May we leave messages concerning your appointments with a co-worker, receptionist, or secretary that regularly answers your calls? YES NO N/A

May we leave detailed messages on your voicemail at work? YES NO N/A

May we leave detailed messages on your voicemail at home? YES NO N/A

May we leave detailed messages on your cell phone? YES NO N/A
(**Please remember that your cell phone is not a secure line**)

Please list names of persons with whom we have permission to discuss your appointments, treatments or financial issues:

Name:	Relationship:
__________________________	__________________________
__________________________	__________________________
__________________________	__________________________
__________________________	__________________________

May we correspond with you via email? YES NO N/A Your email:_

____@________________

You must inform us in writing of any changes in your directives. This consent takes effect on the date indicated below and will be kept in your file along with your acknowledgement of receipt of your Notice of Privacy Practices.

Signature:____Date: ____________________

Print Name:____Date of birth: ______________

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Consent for release of medical Information

Patient's name:____Date of Birth: ______________________

Previous Name (if applicable):____

Doctor's Name: (who should release medical records):

____

Address: ______________________________________

City, State, Zip: ___________________________________

Phone Number: __________________________________

I authorize and give consent to the above doctor to release my health information to the following:

Dallas Medical, PLLC
9900 N Central Expwy Ste 225
Dallas, TX 75231 PLEASE MAIL RECORDS
DO NOT FAX IF OVER 20 PAGES

This request and authorization applies to: (check appropriate line)

____ Health Care information relating to the following treatment condition or dates of treatment:

____

____

____All Health Care information including information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use.

____All Health Care information excluding information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders/ mental health or drug and/or alcohol use.

____
Signature of patient or authorized representative   Date

____
Relationship if signed by anyone other than the patient (parent, legal guardian, personal representative etc.)

This release expires 90 days after the date it is signed.