McKinney Internal Medicine

Vijaya Mummadi, M.D., Rachel Jaison F.N.P.
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PATIENT INFORMATION:
Referred by: [] Google, [] ZocDoc, [] Friend: name _____, [] Physician: name _____, [] Other: _____

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. 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.

Signature_____Date___/___/_____ Account# _____

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NEW PATIENT HISTORY - CONFIDENTIAL

Name: _____ DOB: _____

Social History

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

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

Drug abuse history: Yes/ No Occupation: _____

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

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

Do you exercise regularly? Yes/No

Hearing impairment	Yes/No	Hearing Aid	Yes/No
Snoring	Yes/No	Daytime sleepiness	Yes/No
Do You Drive	Yes/No	Vision impairment	Yes/No

Living will/Advanced directives Yes/No

Medical Power of Attorney Yes/No If yes: Name and contact information _____

DNR (Do Not Attempt Resuscitation) 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 regularly? Yes/No

Sexual Health History

Sexually active: Yes / No, Sexual partners: Male [ ] Female [ ], Sexually transmitted infections if any: _____

Preventive Health History (most recent dates)

Colorectal cancer screening: [ ]colonoscopy: _____ Cardiac stress test: _____

[ ]stool for occult blood _____ Skin exam: _____

Bone density scan (DEXA): _____ Dental exam: _____

Diabetic eye exam / Regular eye exam: _____ Diabetic foot exam: _____

Immunizations dates:

[ ] Flu Vaccine: _____ [ ] Shingles Vaccine: _____

[ ] Pneumonia Vaccine: _____ [ ] Cervical Cancer Vaccine (Gardasil): _____

[ ] TdaP (Tetanus+whooping cough) Vaccine : _____ [ ] Hepatitis B Vaccine: _____

Women: **Men**:

Date of last PAP smear: _____ Date of last rectal exam:

Date of last mammogram: _____ Date of last PSA: _____

Do you perform regular self- breast exams? Yes/ No Do you perform regular self-testicular exams? Yes/No

Patient Signature: _____ Date: _____

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NEW PATIENT HISTORY FORM

Name: _____ DOB: _____

Pharmacy name and phone number: _____

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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Medical Release of Information Form

Patient's name: _____Date of Birth: _____

Previous Name (if applicable): _____

I authorize and consent the following doctor to release my records:

Doctor's Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Fax number: _____

Please release the medical record of the above name patient to:

McKinney Internal Medicine,
8951 Collin McKinney Pkwy #301,
McKinney, TX 75070
Ph: 214-556-0847, Fax: 214-556-0850

PLEASE MAIL RECORDS DO NOT FAX IF OVER 20 PAGES

This request and authorization applies to: (initial 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.

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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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NOTICE OF PRIVACY PRACTICES

Effective Date:_____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

YOUR PRIVATE HEALTH INFORMATION (PHI)

Each time you have contact with a healthcare provider for delivery of healthcare, a record of your contact/visit is prepared. This record, maintained in written, oral or electronic format, contains presenting signs/symptoms, results of examination and test, diagnosis, treatment and future care. Your medical record is the physical property of the **PRACTICE,** but you have certain rights to restrict some of the uses or disclosures of the information in your medical record. The **PRACTICE**, however, has the right to use and disclose the information contained in your medical record in the process of providing treatment, receiving payment and performing other regular healthcare operations such as:

Documenting and describing the care you received for legal purposes.

Communicating with other healthcare providers who may be involved in your care

Educating health care professionals

Medical research

Providing information for government and public health entities responsible for improving public health and welfare

Evaluating and improving the care you receive and the outcomes achieved

Billing and verification of services provided to you

Conducting other routine healthcare operations such as quality improvement studies and assessing healthcare provider competence

Protecting your privacy and maintaining the security of your health information is one of the most important responsibilities of the **PRACTICE**. The **PRACTICE** is required by law to maintain privacy and confidentiality of your health information, provide you with this *Notice of Privacy Practices*, notify you if the **PRACTICE** is unable to agree to a requested restriction, and allow you to review the *Notice of Privacy Practices* prior to granting consent and notifying you of changes/revisions to this Notice.

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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 co-workers.

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 voice mail at work? YES NO N/A

May we leave detailed messages on your voice mail 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: _____