Valora Medical Group

PATIENT INFORMATION FORM

PATIENT INFORMATION

Patient's Name: (Last) _____ (First) _____ (MI) _____

Address: _____

City, State, Zip: _____

Home: _____ Cell: _____ Work: _____

E-Mail Address: _____ DOB: _____

Sex: ☐ Female ☐ Male ☐ Transgender

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Language: ☐ English ☐ Spanish ☐ Indian: Hindi, etc. ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Social Security Number: _____ - _____- _____

RESPONSIBLE PARTY INFORMATION (*If not self*)

(Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐

Responsible party name: (Last) _____ (First) _____ (MI) _____

Date of birth: MM _____/DD _____/YYYY_____ Sex: ☐ Female ☐ Male

Social Security Number: _____-_____-_____ Phone number: _____

Address: _____

City, State: _____ ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last) _____ (First) _____

Phone number: _____ Do you have a living will? ☐ Yes ☐ No

Emergency contact relationship to patient: _____ ☐ Guardian

Address _____

City, State: _____ ZIP: _____

Home phone: _____ Work hone: _____ Ext. _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: _____ Date: _____

Printed name of patient or personal representative: _____ Relationship to patient: _____

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HEALTH HISTORY QUESTIONNAIRE

Name *(Last, First, M.I.):* ☐ M ☐ F		**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Previous or referring doctor:	**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

Problems

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

	Current	Past		Current	Past		Current	Past		Current	Past
Allergic rhinitis	☐	☐	Cancer, Melanoma	☐	☐	Epilepsy (seizures)	☐	☐	Kidney Stones	☐	☐
Alzheimer	☐	☐	Cancer, Ovarian	☐	☐	Erectile Dysfunction	☐	☐	Low back pain	☐	☐
Anemia	☐	☐	Cancer, Prostate	☐	☐	Fibromyalgia	☐	☐	Lupus	☐	☐
Anesthesia issues	☐	☐	Cancer, Skin (exc Melanoma)	☐	☐	Gallstones	☐	☐	Lymphoma	☐	☐
Aneurysm	☐	☐	Cardiomegaly	☐	☐	Gastritis	☐	☐	Macular degeneration	☐	☐
Angina	☐	☐	Cardiomyopathy	☐	☐	Glaucoma	☐	☐	Menorrhagia	☐	☐
Anxiety	☐	☐	Carotid artery stenosis	☐	☐	GERD	☐	☐	Migraines	☐	☐
Aortic stenosis	☐	☐	Cataract	☐	☐	Gout	☐	☐	Myocardial Infarction	☐	☐
Arterial thrombosis	☐	☐	Chronic Kidney Disease	☐	☐	Heart Attack	☐	☐	Osteoporosis	☐	☐
Arthritis (Osteo)	☐	☐	Colon Polyp	☐	☐	Hematuria (Blood in Urine)	☐	☐	Peripheral Arterial Disease	☐	☐
Arthritis (Rheuma)	☐	☐	Cong. Heart Fail(CHF)	☐	☐	Hemorrhoids	☐	☐	Overactive Bladder	☐	☐
Atrial Fibrillation	☐	☐	Constipation	☐	☐	Hepatitis A, B, C (circle type)	☐	☐	Pancreatitis	☐	☐
B12 deficiency	☐	☐	Coronary Artery Disease	☐	☐	High Cholesterol	☐	☐	Rectal Bleeding	☐	☐
Back Pain	☐	☐	Depression	☐	☐	High Blood Pressure	☐	☐	Stent, Leg	☐	☐
Cancer, Breast	☐	☐	Diabetes Type 1	☐	☐	Hyperthyroidism	☐	☐	Stent, Heart	☐	☐
Cancer, Colon	☐	☐	Diabetes Type 2	☐	☐	Hypothyroidism	☐	☐	Tuberculosis	☐	☐
Cancer, Lung	☐	☐	Eczema	☐	☐	Irritable Bowel Syndrome	☐	☐	Other	☐	☐

Any other health problem not listed above

Hospitalization

Year	Reason	Hospital

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HEALTH HISTORY QUESTIONNAIRE

Surgeries		
Year	**Reason**	**Hospital**

Allergies to medications	
Name the Drug	Reaction You Had

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father ☐ Alive ☐ Dead		☐ Hypertension ☐ Diabetes 1 ☐ Diabetes 2 ☐ CAD ☐ Prostate Cancer	**Children**	☐ M ☐ F	
Mother ☐ Alive ☐ Dead		☐ Hypertension ☐ Diabetes 1 ☐ Diabetes 2 ☐ CAD ☐ Breast Cancer ☐ Ovarian Cancer		☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☑ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*	☐ Alive ☐ Dead	
	☐ M ☐ F		**Grandfather** *Maternal*	☐ Alive ☐ Dead	
	☐ M ☐ F		**Grandmother** *Paternal*	☐ Alive ☐ Dead	
	☐ M ☐ F		**Grandfather** *Paternal*	☐ Alive ☐ Dead	

HEALTH MAINTENANCE

			DATE OF LAST
Have you ever had an EKG?	☐ Yes	☐ No	
Have you ever had a Colonoscopy	☐ Yes	☐ No	
Have you ever had a blood transfusion?	☐ Yes	☐ No	
Have you ever had a Prostate Exam? (Man Only)	☐ Yes	☐ No	
Have you ever had Mammogram? (Woman Only)	☐ Yes	☐ No	
Have you ever had a Dexa Exam? (Woman Only)	☐ Yes	☐ No	
Have you ever had a Pap? (Woman Only)	☐ Yes	☐ No	
Have you ever had a Blood Work?	☐ Yes	☐ No	

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HEALTH HISTORY QUESTIONNAIRE

SOCIAL HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise (choose one)	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day? dwrv					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind? ☐ Beer	☐ Wine	☐ Hard Liquor			
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day svs	☐ Chew - #/day sv	☐ Pipe - #/day sevs	☐ Cigars - #/day srvs		
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No

PREFERRED PHARMACY TO SEND YOUR PRESCRIPTIONS TO

		Pharmacy Address and Phone #
Pharmacy	☐ COSTCO	
	☐ CVS	
	☐ Publix	
	☐ Target	
	☐ Walmart	
	☐ Walgreens	
	☐ Other (specify)	
Mail Order Pharmacy	☐ AARP Medicare	
	☐ CIGNA TelDrug	
	☐ CVS Caremax	
	☐ Innoviant	
	☐ MEDCO	
	☐ Walmart	
	☐ Other (specify)	

Patient Name: _____ Acc No: _____

STANDING CONSENT TO ACCESS EXTERNAL PRESCRIPTION HISTORY

PLEASE SIGN ONLY AFTER YOU HAVE READ AND UNDERSTAND ALL OF THE FOLLOWING

I, _____, whose signature appears below, authorize Valora Medical Group and its Affiliated Providers to view my external prescription history via the RXHUB service.

By initialing, you agree to the terms and conditions set out below and are agreeing to the terms above.

Please initial

_____ I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my Valora provider and staff.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTAND THAT I AUTHORIZE THE ACCESS.

_____ _____

Signature of Patient Date and Time

_____ _____

Witness (office staff use only) Date

Valora Medical Group

HEALTH HISTORY QUESTIONNAIRE

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Patient Signature: _____ Date: _____

Valora Medical Group

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION TO VALORA

Fill out this form if you want your records from your previous doctor be sent to our office.

Patient's Name: _____ DOB: _____

Previous Name: _____ SSN: _____

Address: _____ City: _____

State: _____ Zipcode: _____ Phone: _____

I request and authorize release healthcare information of the patient named above from:

Physician Name: _____

Address: _____

Phone: _____ Fax#: _____

Records as listed below should be mailed or faxed to **VALORA Medical Center** to the address or fax listed at the bottom. This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

Witness: _____ Date Signed: _____

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME, EXCEPT WHERE INFORMATION HAS ALREADY BEEN RELEASED. THIS AUTHORIZATION IS VALID FOR UNTIL REVOKED IN WRITING BY ME.

VALORA MEDICAL GROUP
5601 Executive Drive, Suite 200
Irving, TX 75038
Office: (469) 833-2731 • Fax: (817) 697-4179

Valora Medical Group

DESIGNATION OF HEALTH CARE

Patient Name: _____
(Last) (First) (Middle Initial)

I give permission to Valora Medical Center to discuss any of my medical information with the following individuals:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Surrogate Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my Alternate surrogate:

Surrogate Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

I fully understand that this designation will permit my designee to make health care decisions, except for anatomical gifts, unless I have executed an anatomical gift declaration pursuant to law, and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility. I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility.

_____ _____

Patient Signature Date