ELDORADO FAMILY MEDICINE

NEW PATIENT PAPERWORK

Today's Date ________________ **Today's Visit Reason** ____

First Name ______________________________ **Last Name** ______________________________

Home Address ____

City ______________________________ **State** ______________ **Zip Code** ______________

Cell # ______________________________ **Email** ____

Date of Birth ______________________ **Marital Status** Divorced Married Single Widow

Sex Female Male **Occupation** ____

Referred By ☐ Google ☐ Insurance ☐ Commercial ☐ HEB Advertisement ☐ Patient/ Doctor If yes, Name ________________

Spouse's Name ____ **Spouse's Date of Birth** ______________

Cell # ______________________________________ **Alternate #** ______________________________

Emergency Contact Name ____

Emergency Contact Relationship ______________________________ Cell# ______________________

Other Patient Information-Circle all that are applicable

Race Africa American Asian Asian Indian Native American Pacific Islander White Declined Other ______________

Ethnicity Hispanic/Latino Non-Hispanic/Latino Declined Other ______________________

Insurance Information

Primary Insurance Policy ____

Name of Insurance Holder ______________________________________ **DOB** ______________________

Group # ______________________ **Member ID/Subscriber #** ____________________________________

Employer Name ____

Secondary Insurance Policy ____

Name of Insurance Holder ______________________________________ **DOB** ______________________

Group # ______________________________________ **Policy #** ______________________________________

ELDORADO FAMILY MEDICINE

GENERAL CONSENT FORM

Today's Date ______________

Patient's Name ______________________________ **Date of Birth** ______________

Read every section on this form and initial after each statement that you understand and agree to the information.

Assignment of Benefits: I authorize Eldorado Family Medicine, ("EFM") to submit claims on my behalf directly to my health insurance carrier. This means that EFM will collect payment for all supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid by the insurance company. I authorize you to release any information necessary to my insurance company, regarding illnesses and treatment to process claims. This assignment will remain in effect until revoked by me in writing.

Patient's Initials ______________

Consent for Treatment: I consent for EFM to administer and/or order treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives.

Patient's Initials ______________

Electronic Prescription: I understand EFM utilizes electronic prescribing and if my pharmacy does not offer electronic prescribing, I understand that EFM will either given me a hard copy or will fax my prescriptions
I understand that Dr.Lin does not write prescriptions for controlled medications or narcotics on a regular basis, however, if he does write one he will first check my prescription history with the Texas Prescription Monitoring Program, (TPMP) online portal. Dependent upon my history of controlled prescriptions, or information that is obtained via the pharmacy, EFM reserves the right to cancel a controlled substance prescription.

Patient's Initials ______________

Patient Portal: I understand EFM utilizes electronic records that are accessible via the Patient Portal and the Healow app. I understand that all of my lab results will be available on the patient portal after they have been reviewed with me either by phone or appointment and will not be printed in the office except in extenuating circumstances. I understand that I can communicate with the staff and access my records via my patient portal. I understand that by providing my email address I am opting in to my patient portal.

Email ______________________________ **Patient's Initials** ______________

Phone Calls: By providing contact information, I authorize EFM, its assignees, and third party collection agents to use the contact information I have provided to communicate with me and to place calls to my home or cell phone; leave voice or text messages; and use pre-recorded/artificial/voice messages in connection with any communication to me.

Patient's Initials ______________

GENERAL CONSENT FORM-CONTINUED

Today's Date ______________

Patient's Name ______________________________ **Date of Birth** ______________

Involvement of Others in Care: I authorize EFM and it's staff to discuss my/the patient’s care and medical needs with the following persons:

Name	Date of Birth	Relationship	Phone Number

☐ I **DO NOT** wish to add any additional contact person to discuss my/the patient's needs.

How May We Contact You By Phone and Leave a Message About Your Care?

Main Phone # ______________________

☐ Leave message with contact number only.
☐ Leave message with detailed information.
☐ Do not leave message.

Other Phone# ______________________

☐ Leave message with contact number only.
☐ Leave message with detailed information.
☐ Do not leave message.

Patient Financial Policy
I acknowledge the receipt of the "Patient Financial Policy." **Patient's Initials** ______________

Notice of Privacy Practices
I acknowledge the receipt of the "Notice of Privacy Practices." **Patient's Initials** ______________

____ ______________
Signature of Patient or Personal Representative Date

____
Print Name of Patient or Personal Representative and Relationship if not the patient

ELDORADO FAMILY MEDICINE

MEDICAL HISTORY FORM

Today's Date ____________

Patient's Name ______________________________ **Date of Birth** ____________

PHARMACY (List the pharmacy most frequently used for prescriptions. We will only have one pharmacy on file at a time and we will only send the pharmacy listed.)

Name: ______________________________ Phone # ____________

Address ______________________________ City ____________

MEDICAL HISTORY-Past or Present (Please list all conditions that you have had or currently have. You can attach an additional sheet if needed)

Condition	Date Diagnosed	Treatment	Date Resolved

List ALL other medical providers (Primary Care, Specialists, and others) you are currently seeing or have seen in the past. Format Name, Specialty, year seen. (i.e. Dr. Tom Johnson-Cardiologist-2020 etc):

____

____

ALLERGIES (include medication, foods, x-ray dyes)	**No Known Allergies** ☐	
Name of allergen (i.e. Lisinopril)	Type of reaction (i.e. rash)	Date started

CURRENT MEDICATIONS (Attach an extra sheet if needed)				**None** ☐
Name of medication (i.e. Metformin)	Dose (i.e. 500 mgs)	How often taken (i.e. Twice a day)	Reason for taking/Current Diagnosis (i.e.	Name of Doctor prescribing

ELDORADO FAMILY MEDICINE

MEDICAL HISTORY FORM-CONTINUED

Today's Date ______________

Patient's Name ______________________________ **Date of Birth** ______________

PREVIOUS HOSPITALIZATIONS (include all non surgical hospitalizations. Attach an extra sheet if needed)		**None** ☐
Reasons for hospital stay	**Date (approximate)**	**Hospital Name**

SURGERIES (include all surgeries or procedures in your lifetime. Attach an extra sheet if needed)		**None** ☐
Surgery or Procedure	**Date (approximate)**	**Hospital or Surgeon Name**

FAMILY HISTORY (List all family history. Attach an extra sheet if needed)			**None** ☐
Relative	**Significant Medical Problem**	**Age at Diagnosis**	**Current Age** (or age when deceased)
Father			
Mother			
Children			
Brother			
Sister			
Grandfather	Maternal Paternal		
Grandmother	Maternal Paternal		
Aunts			
Uncles			

OB/GYN HISTORY # of Pregnancies ________ # of Deliveries ________ Last Menstrual Cycle ________

TOBACCO HISTORY

Are you an active cigarette smoker? Yes ☐ No ☐

Have you ever been a cigarette smoker? Yes ☐ No ☐

If yes, I smoked an average of: ________ packs a day for ________ years.

What year did you quit smoking. ______________

Do you use other tobacco products? Yes ☐ No ☐

If yes, please specify what you use:

ALCOHOL AND DRUG HISTORY

Have you ever been diagnosed with alcoholism? Yes ☐ No ☐

Do you currently drink alcohol regularly? Yes ☐ No ☐

If yes, approximately how many drinks per week (beer, wine, or liquor)

Have you ever used intravenous drugs? Yes ☐ No ☐

Have you ever used any drugs? Yes ☐ No ☐

If yes, what type of drugs have you used and when? ______________________

ELDORADO FAMILY MEDICINE

MEDICAL HISTORY FORM-CONTINUED

Today's Date ____________

Patient's Name ______________________ **Date of Birth** ____________

Please check the box next to all the conditions that apply currently or in the past.

Past	Present	Condition	Past	Present	Condition
General Health			**Gastrointestinal**		
☐	☐	Change in appetite	☐	☐	Abdominal Pain
☐	☐	Fatigue	☐	☐	Blood in Stool
☐	☐	Fever/Chills	☐	☐	Colon Polyps
☐	☐	Weight Gain	☐	☐	Constipation
☐	☐	Weight Loss	☐	☐	Diarrhea
Eyes			☐	☐	Diverticulitis
☐	☐	Blurred Vision	☐	☐	Heartburn
☐	☐	Cataracts	☐	☐	Hemorrhoids
☐	☐	Double Vision	☐	☐	Hepatitis
☐	☐	Glaucoma	☐	☐	Hernia
Head, Ears, Nose, Throat			☐	☐	Irritable Bowel Syndrome
☐	☐	Hay Fever (pollen allergy)	☐	☐	Jaundice
☐	☐	Hearing Loss	☐	☐	Liver Disease
☐	☐	Hoarseness	☐	☐	Nausea
☐	☐	Lumps/Swelling in Neck	☐	☐	Ulcers
☐	☐	Sinusitis/sinus problems	☐	☐	Vomiting
☐	☐	Sore Throat	**Genital and Reproductive**		
☐	☐	Trouble Swallowing	☐	☐	Genital Wart/HPV
Cardiovascular (Heart)			☐	☐	Infertility
☐	☐	Chest Pain	☐	☐	STDs
☐	☐	Heart Murmur		**Females Only**	
☐	☐	High Blood Pressure	☐	☐	Irregular Bleeding
☐	☐	High Cholesterol	☐	☐	Painful Intercourse
☐	☐	Irregular Heart Beat	☐	☐	Vaginal Discharge
Respiratory				**Males Only**	
☐	☐	Asthma	☐	☐	Difficulty Achieving an Erection
☐	☐	Cough	☐	☐	Pain in Testicles
☐	☐	Ephysema/COPD	☐	☐	Prostate Enlargement (BPH)
☐	☐	Pneumonia	**Mental Health**		
☐	☐	Shortness of Breath	☐	☐	ADD/ADHD
☐	☐	TB	☐	☐	Alcohol/Drug Problem
Skin, Hair, Lymph Nodes			☐	☐	Anxiety/Panic Attacks
☐	☐	Acne	☐	☐	Depression
☐	☐	Bruising	☐	☐	Eating Disorder
☐	☐	Eczema	☐	☐	History of Physical/Mental Abuse
☐	☐	Hair Loss	☐	☐	Insomnia
☐	☐	Lymph Node Swelling	☐	☐	Mood Swings
☐	☐	Rash	☐	☐	Stress
☐	☐	Skin Changes	☐	☐	Suicidal
☐	☐	Other	☐	☐	Other

ELDORADO FAMILY MEDICINE

MEDICAL HISTORY FORM-CONTINUED

Today's Date ____________________

Patient's Name ______________________________ **Date of Birth** ____________________

Please check the box next to all the conditions that apply currently or in the past.

Past	Present	Condition
Urinary		
☐	☐	Frequent Urination
☐	☐	Incontinence (loss of urine control)
☐	☐	Kidney Disease
☐	☐	Slow Urine Stream
☐	☐	Trouble Urinating
Musculoskeletal		
☐	☐	Back Pain
☐	☐	Joint Pain
☐	☐	Muscle Pain
☐	☐	Arthritis
☐	☐	Gout
☐	☐	Muscle Aches
Neuro		
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Headache
☐	☐	Memory Loss
☐	☐	Numbness
☐	☐	Seizures/Epilepsy
☐	☐	Stroke
☐	☐	Weakness
☐	☐	Other
Hem-One and Immunology		
☐	☐	AIDS/HIV
☐	☐	Anemia
☐	☐	Blood Clots
☐	☐	Cancer
☐	☐	Easy Bleeding
☐	☐	Easy Bruising
☐	☐	Sickle Cell Anemia
☐	☐	Transfusion
Breast		
☐	☐	Abnormal Mammogram
☐	☐	Breast Biopsies
☐	☐	Breast Lumps
Endocrine		
☐	☐	Diabetes
☐	☐	Thyroid Disorders

Tests/Immunization	Date
Eye Exam	
Pulmonary Function Test	
Echocardiogram/EKG	
Cardiac Stress Test	
Mammogram	
Bone Density Test/Dexa Scan	
Diabetic Foot Exam	
Colonoscopy/ColoGuard/FIT card	
PAP Smear/Well Woman's Exam	
Influenza/Flu Vaccine	
Pneumonia Vaccine(s)	
Tetanus Vaccine	
Blood Transfusion	
Last Dental Exam	
Last Prostate Exam	
Most Recent Bloodwork	
Last Physical	