New Patient Information Sheet

Last Name First Middle **Previous Name(s)**

Date of Birth Age Sex Social Security Number Marital Status Home Phone

Street Address City State Zip Code

Mailing Address if Different
Street Address City State Zip Code

Work Number Cellular Number Fax Number **E-Mail**

Driver's License Number / State Name of Spouse Emergency Number for Spouse

List other members of your family living in your household

In case of Emergency, Notify **Address** **Phone** **Relationship**

Name of Insurance Policy Number Relationship to the Insured

Name of the Insured **Social Security Number of Insured** **Insured Date of Birth**

Address of Insured if different from patient address Employment / Student Status

Whom may we thank for referring you to our office

How do you plan to pay for today's visit? Cash Check Credit Card Insurance

Local Pharmacy_____ Mail Order Pharmacy_____

OUR FEE POLICY
To help control cost, we ask our patients to pay for their visits at the time of service. For all "No Show" appointments there is fee of $30.00

I have been notified of the Notice of Privacy Practices for Tomball Familicare.

Signature of Patient or Legal Guardian Date

Government required reporting information

Name_____ Date of birth_____

E-mail address _____

*Email address **must** be in this format*: **thisishowiaccessmymedicalrecord@drwhiteleyspatientportal.com**

The format of the following questions and answers has been provided by the United States government. Please indicate your answer by circling one of the choices provided.

Race :

American Indian or Alaska Native	Black or African American	Other Race
Asian	White	Other Pacific Islander
Native Hawaiian or other Pacific	Hispanic	**Unreported/ refused to report**

Ethnicity:

Hispanic or Latino	Not Hispanic or Latino	**Refused to report**

Language:

English	Other	Spanish
Indian (include Hindi &Tamil)	Russian	

Do you require a translator to communicate with English speaking people:

Yes No

Health History

PATIENT'S NAME: _____

REASON(S) FOR VISIT TODAY: _____

HOSPITALIZATIONS OR MAJOR ILLNESS OR MAJOR INJURIES:

YEAR	DESCRIBE ILLNESS, INJURY, OPERATION, OR BIRTH	YEAR	DESCRIBE ILLNESS, INJURY, OPERATION OR BIRTH
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HEALTH PROBLEMS (Illness you could inherit): Grandparents_____

Mother _____ **Father**_____

Brother/s _____ **Sister/s** _____ **Aunts/Uncles** _____

YOUR HEALTH PROBLEMS: Please mark (P) for 'past' & (C) for 'current' **Explanation**

Ear Problems: ( ) Hearing problem ( ) Ears ringing/tinnitus ( ) Wear hearing aids ( ) Dizzy spells ( ) Ear wax problem ( ) Ear pain ( )Other_____

Eye Problems: ( ) Decreased vision ( ) Eye pain ( ) Glaucoma ( ) Cataracts ( ) Blurred vision ( ) Double vision ( ) Macular degeneration ( ) Other_____

Nose/Sinus Problems: ( ) Allergies ( ) Nose bleeds ( ) Sinus infections ( ) Chronic sore throat ( ) Hoarseness ( ) Other _____

Lung Problems: ( ) Pneumonia ( ) Pleurisy ( ) Cough ( ) Bronchitis ( ) Asthma or wheezing ( ) Shortness of breath ( ) Other_____

Chest or Heart Problem: ( ) Chest pain ( ) Angina ( ) High blood pressure ( ) Heart condition ( ) Murmur ( ) Irregular pulse ( ) Other_____

Circulation Problems: ( ) Leg pain ( ) Cold feet ( ) Varicose veins ( ) Blood clots or phlebitis ( ) Swollen feet ( ) Other_____

Digestive/Intestine Problem: ( ) Loss of appetite ( ) Difficult to swallow ( ) Heartburn ( ) Ulcers ( ) Reflux ( ) Nausea ( ) Vomiting _____

( ) Abdominal pain ( ) Jaundice ( ) Hepatitis ( ) Gallbladder trouble ( ) Diarrhea ( ) Constipation ( ) Malabsorption _____

( ) Diverticulosis/Diverticulitis ( ) Crohn's disease. ( ) Colitis ( ) Bloody stools( ) Tar like stools ( ) Hemorrhoids ( ) Hernia ( ) Other_____

Kidney/Urinary Problems: ( ) Overactive bladder ( ) Excessive night time urination ( ) Urgency to urinate _____

( ) Urinary leakage ( ) Decrease urine flow ( ) Exercise or cough incontinence ( ) Blood in urine ( ) Pain or burning on urination _____

( ) Urine infections ( ) Excessive urination ( ) Kidney stones ( ) Prostate problems/enlarge prostate/BPH ( ) Other_____

Nerve/Brain Problems: ( ) Headaches ( ) Migraines ( ) Tremor/hands shake ( ) Seizures/Epilepsy ( ) Stroke ( ) Numbness ( ) Memory loss_____

Muscle/Joints/ Bones: ( ) Limb weakness ( ) Arthritis or joint pain ( ) Back pain, recurrent ( ) Gout ( ) Broken bone or joint injury _____

( ) Osteoporosis ( ) Lupus ( ) Fibromyalgia ( ) Muscle cramps ( ) Muscle pain ( ) Scoliosis/Curvature of spine ( ) Other_____

Skin Problems: ( ) Rashes ( ) Hives ( ) Psoriasis ( ) Eczema ( ) Skin cancers ( ) Recurrent skin infections or boils ( ) Hair loss ( ) Other_____

Emotional/Psychiatric: ( ) Nervousness ( ) Depression ( ) Concentration problems ( ) Sleep problems ( ) Mood swings ( ) Other_____

( ) Suicide thoughts ( ) Suicide attempts ( ) Past mental problems or treatment ( ) Past/Present "nerve or antidepressant pills"_____

( ) Panic Attacks ( ) Anxiety ( ) Decreased Sex/Life Enjoyment ( ) Past DWI ( ) Past Criminal/Felony Arrest or Conviction _____

( ) Marital problems ( ) Marital abuse ( ) Hallucinations ( ) Alcohol abuse ( ) Drug abuse (Street or prescription abuse) _____

Endocrine/Gland Problems: ( ) Diabetes ( ) Thyroid problems ( ) Female/Estrogen hormone problems ( ) Male/Testosterone problem_____

( ) Penile erection problems/Erectile dysfunction ( ) Vaginal dryness ( ) Hot flashes ( ) Pituitary/Growth hormone problems_____

Past or current Infections: ( ) Tuberculosis ( ) Malaria ( ) Measles ( ) Chickenpox ( ) Rheumatic Fever ( ) Polio ( ) Mumps _____

( ) German Measles/Rubella ( ) Herpes ( ) STD's ( ) Gonorrhea ( ) Syphilis ( ) Chlamydia ( ) HIV/AIDS …_____

( ) Hepatitis ( ) Whooping cough/Pertussis ( ) Staph. Infections/Boils ( ) Lyme Disease ( ) Other infectious diseases_____

Other Problems: ( ) Excessive snoring ( ) Fainting Spells ( ) Anemia ( ) Bruise easily ( ) Blood disorders ( ) Easily fatigued ( ) Nutrition problem _____

( ) Cancer (Type?) When Diagnosed? How was it treated?):_____

Substance usage: ( ) Alcohol, type _____Amount _____( ) Coffee_____ cups/day ( )Tea _____Glasses/day _____

( ) Current tobacco use _____ packs/day ( ) Past tobacco smoker _____Years of use ( ) Street/ illicit drugs, types _____

Health Habits: ( ) Exercise, type_____ Frequency _____ Currently Dieting?: ( )Yes ( )No_____

Past Vaccinations/year given: ( )Flu/year_____( )Tetanus(Td)/year_____( )Pneumonia/year_____( )Hepatitis/year_____( )Tuberculosis test/year_____**Past Testing/year done:** Last general physical/year_____ Rectal or stool testing/year_____ Cholesterol/year_____ Eye/year_____ Dental exam/year_____

Female/Menstruation History: ( ) Abnormal Vaginal Discharge ( ) Vaginal Irritation ( ) Vaginal Dryness ( ) Frequent Vaginal Infections _____

Menstruation: ( ) Regular ( ) Irregular ( ) Cramps or pain ( ) Length of menstrual flow in days_____ List 1st day of last menstrual period: _____

Female Sexual problems: ( ) Pain during or after intercourse ( ) Bleeding during or after sex ( ) Loss of sexual desire ( ) Difficulty with orgasm or climax _____

Pregnancies: Total Number of Pregnancies_____ Induced (Legal) Abortions _____ Miscarriages _____ Premature (Live) Births _____Full Term (Live) Births _____

Current Birth Control Method: _____ Do you desire birth control counseling or prescription? ( ) Yes ( ) No

Date of last Pap _____ ( ) Normal ( ) Abnormal Date of last mammogram:_____ ( ) Normal ( ) Abnormal

Social History: Employed ( ) Yes ( ) No Job description_____ Past Work Injury/Description_____

Current Married: ( ) Yes ( ) No ( ) Never Number of past divorces_____ Education Level_____ Hobbies_____

Medication History (Only medications you are currently taking): Please include vitamins, herbal remedies, and supplements****

Drug Name	Strength	Doses Per Day	Drug Name	Strength	Doses Per Day
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

List any medication reactions or allergies (Please describe type of reaction): _____

_____

I certify this is a true, accurate and complete medical history: _____ _____

Signature of patient or guardian **Date**

Authorization of Assignment

To: MICHAEL J. WHITELEY D.O. / D.B.A. TOMBALL FAMILICARE

In consideration of your undertaking to treat me, I agree to the following:

Authorization to Release Information

You are authorized to release any information you deem appropriate concerning my physical or mental condition to any insurance company, attorney or adjuster in order to process any insurance claim for reimbursement of charges incurred by me as a result of medical services rendered by you or your staff, and I hereby release you of any consequences thereof.

On Site Inspection Release

I authorize my Insurance Company Representative to review information contained in my medical records for their routine inspections.

Assignment of Cause of Action

In the event any insurance company is obligated by contractual agreement to make payment to me or to MICHAEL J. WHITELEY D.O., D.B.A. TOMBALL FAMILICARE, I hereby assign and transfer to MICHAEL J. WHITELEY D.O. the cause of action that exits in my favor against any such company, and authorize you to prosecute said action either in my name or your name as you see fit, and further authorize you to compromise, settle or otherwise resolve said claim as you see fit.

Authorization to Pay Directly to the Doctor

I authorize and direct my insurance company to make payment to the doctor name above any sum I may now or hereafter owe him. I agree to pay any and all applicable deductibles, and co-pays. I further agree to pay my balance if my insurance company has not paid within 120 days of the date of service.

Date: _____

_____

Signature of Patient/Guardian

Tomball Familicare

Michael J. Whiteley, D.O.
29214 Quinn Road
Tomball, TX. 77375-4486

Phone 281- 351-4208
Fax 281- 351-5417

Nurse Practitioner / Physician Assistant
Consent For Treatment

This facility has on staff a physician assistant (PA) or nurse practitioner (NP) to assist in the delivery of medical care.

A PA / NP is not a doctor. A PA / NP is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a PA / NP can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care. Supervision does not require the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A PA / NP may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Treat minor lacerations and other minor injuries

I have read the above, and hereby consent to the services of a PA / NP for my health care needs.

Upon scheduling my appointment I am given a choice of seeing the doctor, PA / NP . It is my choice alone in which provider I choose for my medical treatment.

I understand that at any time I can refuse to see the PA / NP and reschedule my appointment to see the doctor.

_____ _____

Signature Date

Tomball Familicare

Michael J. Whiteley, D.O.
29214 Quinn Road
Tomball, TX. 77375-4486

Phone (281) 351-4208
Fax (281) 351-5417

Patient Name: _____ DOB: _____

Consent to Obtain Medication History

Our medical practice has adopted an electronic medical record system in order to improve the quality of our service. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous medication interactions

By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression.

This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make medication history available to us, and the medication history from your health plan might not include medications that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in you medication history.

I give permission for Tomball Familicare to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

_____ _____

Patient/Parent/Guardian Signature **Date**

_____

Patient/Parent/Guardian