NEW PATIENT DATA FORM

Date: _____
Last Name: _____**First Name:**_____
Middle Name:_____ **Suffix:** (Circle one) None Jr. III
Address:_____ **Apt#**_____
City/State/Zip_____
Gender: (Circle One) Male Female **Social Security Number:**_____
Marital Status: (Circle One)Single Married Divorced Widow(er) Separated
Date of Birth: _____ **Employer Name:**_____
Spouse's Name:_____ **Employer Name:**_____
If patient is a minor, please complete the following:
Father's Name_____**Mother's Name**_____
Parent's address (if different from above)_____**PHONE**_____
Father's place of employment_____ **PHONE**_____
Mother's place of employment_____ **PHONE**_____
Name, address & phone of relative_____

Primary Care Provider (Circle One) George Richmond, Jr., M.D. Burton Shaw, Jr., M.D.
John Ledbetter, D.O. Kathleen Leinen, D.O.

Phone: Home ( ) _____
Cell ( ) _____
Work ( ) _____Ext_____

E-Mail:_____
Preferred Contact Method (Circle one) home/cell/work phone
Preferred Reminder Method (Circle one) home/cell/work phone
Drivers License Number: _____ State_____ Expiration date:_____

Primary Emergency Contact Information:
Last Name:_____
First Name:_____
Phone Emergency Number One:( )_____
Phone Emergency Number Two:( )_____
Relationship:_____

Local Pharmacy name:_____
Local Pharmacy Phone#: _____
Mail Order Pharmacy name:_____
Mail Order Pharmacy Phone:_____

The following information is required per the new healthcare law to support new meaningful use criteria and government regulations:

Race: (Please Circle One)

Decline American Indian Asian
Black/African American White Other

Ethnic Group: (Please Circle One)

Decline Cuban Hispanic/Latino
Mexican Mexican American

Language: (Circle One) English Spanish Other

Country (Circle One) USA Other

****

Insurance Name:_____Insured:_____Insured DOB:_____

Guarantor's name: _____

Relationship to Guarantor: _____

****METROPOLITAN FAMILY PRACTICE, P.A. HAS CONTRACTED WITH AREA PAYMENT RECOVERY AGENCIES. UPON THE EVENT OF COLLECTION PROCEEDINGS OR INSUFFICIENT FUND RECOVERY OF YOUR ACCOUNT, YOU WILL BE CONTACTED BY THESE AGENCIES. YOU AGREE TO PAY ALL USUAL AND CUSTOMARY FEES ASSOCIATED WITH THESE AGENCIES. IN addition, YOU WILL BE CHARGED AN INSUFFICIENT FUND BANK FEE FOR ALL RETURNED CHECKS AND A COLLECTIONS FEE OF 35% OF THE AMOUNT OWED FOR ALL ACCOUNTS SENT TO OUR COLLECTIONS AGENCY.****

_____ _____

Patient Signature Date

How did you find out about us? _____

PAST MEDICAL HISTORY Do you have or have you ever had: (Circle all that apply)

Diabetes Mellitus	Heart Problems	Asthma	Deafness
High Blood pressure	Heart Attack	Lung Problems	Birth Defects
Rheumatic Fever	Anemia	Thyroid Problems	Mental Illness
Bleeding Disorder	Scarlet Fever	Epilepsy/Seizures	Stroke
Blood Transfusion	Cancer	Gout	Arthritis
Kidney Disease	Hepatitis	Tuberculosis	Pneumonia
Kidney Stone	Migraines	Venereal Disease	Blindness
Liver Problems	Broken Bones	Ulcers	Glaucoma
High Cholesterol	Sinus Problems	Urine Problems	Stomach/Bowel Problems
Amputations	Hemorrhoids		

OTHER:_____

MEDICATIONS: **<u>SPECIFIC NAMES, DOSAGES, FREQUENCY</u>** ***ALWAYS BRING ALL YOUR BOTTLES!!***

_____

_____

_____

_____

MEDICATION ALLERGIES:

_____

_____

PAST SURGICAL HISTORY: List type and year of Surgery

_____

_____

_____

HOSPITALIZATIONS: List Reason and year

_____

_____

_____

<u>PAST OBSTETRICAL AND GYNECOLOGICAL HISTORY</u> (WOMEN ONLY)

AGE AT ONSET OF MENSES_____LENGTH OF CYCLE (# OF DAYS FROM START TO START)_____
NUMBER OF DAYS OF FLOW_____ FLOW: LIGHT____ MEDIUM____ HEAVY____ PAIN OR CRAMPS_____
ANY BLEEDING OR SPOTTING BETWEEN PERIODS_____ MENOPAUSE_____AGE AT ONSET_____
WAS MENOPAUSE NATURAL OR SURGICAL (HYSTERECTOMY)_____

<u>PREGNANCIES</u>

NUMBER OF PREGNANCIES:_____HOW MANY LIVE BIRTHS_____PREMATURE BIRTHS_____
MISCARRIAGES_____ ABORTIONS____ ANY COMPLICATIONS OF PREGNANCY OR CHILDBIRTH_____

FAMILY HISTORY

FAMILY MEMBER	**AGE**	**IF DECEASED: AGE AT DEATH**	**CAUSE**
FATHER:			
MOTHER:			
BROTHERS:			
SISTERS:			
CHILDREN:			
OTHER:			

HAS ANY BLOOD RELATIVE EVER HAD ... ? IF SO, WHO?

DIABETES_____	CANCER_____	BIRTH DEFECTS_____
HIGH BLOOD PRESSURE_____	ANEMIA_____	MENTAL RETARDATION_____
HEART DISEASE_____	GOUT_____	MENTAL ILLNESS_____
HEART ATTACK_____	ULCERS_____	ALLERGIES_____
THYROID DISEASE_____	BLEEDING_____	STROKE_____
KIDNEY STONES_____	DISORDERS_____	GLAUCOMA_____
LUNG DISEASE_____	TUBERCULOSIS_____	OSTEOPOROSIS_____

SOCIAL AND PERSONAL HISTORY

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED SEPARATED
NUMBER OF CHILDREN:_____ NUMBER OF PERSONS IN YOUR HOUSEHOLD:_____
DO YOU OR HAVE YOU WORKED BEFORE. IF SO, DOING WHAT?_____
DO YOU HAVE AN ADVANCED DIRECTIVE? _____YES _____NO
WOULD YOU LIKE ADDITIONAL INFORMATION? _____YES _____NO

PERSONAL HABITS

TOBACCO_____ HOW MANY PACKS PER DAY_____SMOKED HOW MANY YEARS_____
HAVE YOU QUIT SMOKING?_____IF SO, WHEN DID YOU QUIT?_____
DO YOU CURRENTLY DRINK ALCOHOL?_____BEER?_____ WHISKEY?_____ WINE?_____
HOW MUCH DO YOU DRINK PER WEEK? _____ HAVE YOU QUIT DRINKING?_____WHEN?_____
HOW MUCH COFFEE DO YOU DRINK PER DAY?_____
DO YOU USE ANY RECREATIONAL DRUGS?_____WHAT?_____

PERIODIC EXAMINATIONS

WHEN WAS YOUR…….

LAST PAP SMEAR _____	LAST MAMMOGRAM _____
LAST RECTAL EXAM _____	LAST CHEST X-RAY _____
LAST TEST FOR BLOOD IN STOOL _____	LAST EKG _____
LAST COLONOSCOPY _____	LAST BLOOD WORK _____
LAST PNEUMOVAX _____	LAST TETANUS SHOT_____
LAST DIABETIC EYE EXAM_____	LAST BONE DENSITY EXAM_____
LAST FLU SHOT_____	LAST ZOSTAVAX SHOT_____

DO YOU CURRENTLY HAVE.. (PLEASE CIRCLE IF APPLICABLE)

WEAKNESS	HOARSENESS	BLOOD IN STOOLS
LOSS OF APPETITE	COUGH	JAUNDICE
FEVER	COUGHING UP BLOOD	DIARRHEA
CHILLS	WHEEZING	CHANGE IN BOWEL HABITS
WEIGHT LOSS	SHORTNESS OF BREATH WITH EXERCISE	BURNING WITH URINATION
WEIGHTGAIN	CHEST PAIN	FREQUENT URINATION
CHANGES IN HAIR OR SKIN	PALPITATIONS	BLADDER PROBLEMS
HEADACHES	WAKING AT NIGHT SHORT OF BREATH	INCONTINENCE
BEING KNOCKED OUT	PASSING OUT	BLOOD FROM NOSE
BLURRED VISION	SWELLING OF HANDS OR FEET	BLOOD IN URINE
DOUBLE VISION	LUMPS IN BREAST	HOT FLASHES
EYE PAIN	DISCHARGE FROM BREAST	VAGINAL DISCHARGE
LOSS OF VISION	SWALLOWING PROBLEMS	COLD OR HEAT INTOLERANCE
EAR PAIN	INDIGESTION	WEAKNESS OR NUMBNESS OF ARMS
DIZZYNESS	ENLARGED LYMPH NODES	WEAKNESS OR NUMBNESS OF LEGS
RINGING IN EARS	STOMACH PAINS	WEAKNESS OR NUMBNESS OF HANDS
NAUSEA/VOMITING	VOMITING BLOOD	BLACK TARRY STOOLS
GETTING UP AT NIGHT TO URINATE		

PHYSICIAN:_____

ASSIGNMENT OF INSURANCE BENEFITS

In consideration for services rendered by the above physician for medical service provided, I hereby assign and authorize payment directly to the named physician of the benefits otherwise payable to me, but not to exceed the physician's regular charges. I understand I am financially responsible to the physician for charges not covered by this authorization.

_____ _____

SIGNATURE OF PATIENT DATE

AUTHORIZATION TO OBTAIN INFORMATION

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, Medical Information Bureau, Inc., consumer reporting agency, or employer who has information available to them such as diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children to give to: _____any and all such information.

_____ _____

SIGNATURE OF PATIENT DATE

Dear Patient:

Metropolitan Family Practice has verified insurance coverage and will be filing an insurance claim for you.

It is our policy to collect any co-pay, deductible and co-insurance amounts at the time of service. Some procedures done in the office are considered surgical procedures by your insurance company, therefore your benefits may change. Benefits generally are different for office visits then for surgical procedures and most times there is a deductible applied to surgical procedures done in a physicians office.

The deductible amount is the amount due by the patient before your insurance company will begin to pay. Depending on your particular policy, deductible amounts can range from $0 to up to $5,000.00 per calendar year. You will be expected to pay your deductible in full at your office visit. For example, if you have a $250.00 deductible that has not been satisfied, and your charges total $300.00 during your office visit, your insurance company will not pay on the first $250.00. You will be responsible at the time of service for this amount. They will process the remaining $50.00 according to your benefits.

The co-insurance amount is the percentage not covered by your insurance. This percentage can range from 0% to 50% so for example if your insurance pays 80% of the $300.00, you will be responsible for 20% or $60.00.

The physicians at Metropolitan Family Practice, P.A. are contracted with most major insurance plans therefore discounts will be applied accordingly. The amount we collect from you is determined by the information provided to us by your insurance company and we will do our best to collect the correct amount, however, **the amount we collect is an approximation** and it may not be the final amount due.

We will allow your insurance company six (6) weeks to issue payment. Metropolitan Family Practice will keep in touch with you regarding non-payment, payments received and the balance due until total charges have been paid in full. If a balance remains outstanding after all insurance payments have been received, regardless of coverage quoted by your insurance company, you will be responsible for that balance.

We provide the following services:
(1) Office Visits
(2) Diagnostic Testing
(3) Office Procedures

If there is a request for a Pathology service, that charge is also separate. We will provide the laboratory with your insurance information and they will file a claim on their charges for you.

****AS A COURTESY, OUR OFFICE WILL FILE A CLAIM FOR YOU TO YOUR INSURANCE COMPANY. HOWEVER, IT BECOMES THE RESPONSIBILITY OF THE PATIENT TO INSURE PROPER PROVIDER NETWORK BENEFITS FOR COMPLETE REIMBURSEMENT.**

I HAVE READ AND FULLY UNDERSTAND THE ABOVE INFORMATION.

_____ _____

RESPONSIBLE PARTY DATE

Attn: Medicare and Medicaid Patients:

I understand that the services or items that I have requested to be provided on this date may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the Texas Department of Health or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

_____ _____

RESPONSIBLE PARTY DATE

Metropolitan Family Practice, P.A. would like to welcome you to our office. We appreciate the opportunity to serve you. The following information is provided for your benefit so that we may better serve you. Please read, initial and sign at the bottom. A copy will be given to you for your records.

Initials

_____ 1. **PAYMENTS.** All applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of your appointment. We accept cash, checks, Visa, Mastercard, Discover or American Express. There will be a charge for all non-sufficient fund/returned checks billed directly to you by our recovery agency.

_____ 2. **CANCELLATIONS/NO SHOWS.** If you need to cancel your appointment, be sure to call us at least 24 hours before your scheduled appointment. You will be charged $25.00 for late cancellations or missed appointments unless you had an emergency. If you fail to notify us of three missed appointments, we may decide to terminate care with our office. You may receive a reminder phone call prior to your appointment. However, failure to receive a reminder phone call will not change our policy. Please record your appointment on your calendar.

_____ 3. **APPOINTMENT TIME.** We ask that our patients arrive on time for their appointment; this will facilitate our ability to see you as scheduled. Patients arriving past their appointment time may need to be rescheduled.

_____ 4. **CHANGE OF INFORMATION.** Please provide us with any change regarding your address, phone numbers or insurance information as soon as possible. This is your responsibility, each visit.

_____ 5. **YOUR ATTENDING PHYSICIAN.** Once you have selected a physician, he/she will be your Attending Physician throughout your course of care here at this office. If your physician is unavailable, another physician may treat you in his/her absence. You will return to the care of your Attending Physician upon his/her return.

_____ 6. **MEDICATION REFILL REQUESTS.** We request that you contact your pharmacy first and they will contact our office with the necessary information to refill your medication. **No refills will be done after hours**. Please request refills **1 week** prior to your running out.

_____ 7. **LAB AND X-RAY RESULTS.** We want all of our patients to call 72 hours after having laboratory or radiology testing for their results. We have on staff a Patient Relations Coordinator that you may call. You will be directed to her voice mail to leave a detailed message so she can properly respond to your request and speak with your physician regarding your results. Due to the high volume of calls we receive daily, however, please allow 24 to 48 hours to hear back from her.

_____ 8. **AFTER HOURS CARE.** If it is an emergency, please call 911. If you need to speak with your Attending Physician after hours, please call our main number at (210) 227-9214 and you will reach our answering service who will contact your physician. Your physician will return your call as soon as possible.

_____ 9. **INSURANCE VERIFICATION.** This office will verify your benefits to the best of our ability once you supply your correct insurance information. Verification of coverage does not mean that all service rendered will be covered during your visit, however, and uncovered services, supplies and/or treatments may be your responsibility to pay.

_____ 10. **REFERRALS TO SPECIALISTS.** All referral requests need to be obtained at least 1 week in advance. Same day routine referrals may not be authorized. If your physician wants to send you to a specialist, our policy will be to attempt to contact you by phone on 3 consecutive days. After 3 attempts to reach you by phone, a letter will be mailed to you advising you of the referral and it will then become your responsibility to contact us regarding the referral. Your insurance requires that the referral must be completed within 90 days (for Humana Gold 30 days). If you do not get the referral done in the time allowed and the referral has to be re-issued, you will be charged a **$25.00 administrative fee.** This is not reimbursed by your insurance company.

_____11. **YOUR MEDICATIONS.** ALWAYS bring all of your medication bottles for all of your visits. Failure to do this may result in having to reschedule your appointment.

_____ 12. **NON-COMPLIANCE.** We reserve the right to discontinue your care with our office for non-compliance of any of the above policies.

"I, the Guarantor of Payment and Responsible Party; agree to the above policies and agree to the terms regarding payment and payment responsibilities."

_____ _____

Signature of Responsible Party Printed name of Responsible Party

_____ _____

Patient Name if different Witness Signature and date

_____

Date

George M. Richmond, Jr., M.D.
Diplomate American Board of Family Practice

Burton G. Shaw,Jr., M.D.
Diplomate American Board of Emergency Medicine

John D. Ledbetter, D.O.
Diplomate American Osteopathic Board of Family Practice

Kathleen A. Leinen, D.O.
Diplomate American Osteopathic Board of Family Practice

PATIENT CONSENT FOR RELEASE OF MEDICATION HISTORY

In order to better evaluate your healthcare needs and aid your doctor in his/her efforts to provide you with the best care, it would be beneficial for your doctor to know all of the medications you have been or are currently taking. We now have the capability to electronically receive all of your current and past medication history from your insurance company and download them into your electronic file here. This will help your doctor evaluate all of your medications at a glance and determine what your medication needs are. Your doctor will be able to see what your other doctors are prescribing you and better evaluate how any new medications may interact with your complete list of medications. In order to receive your complete medication history we need your permission to do so. Please check off below whether you give your consent to receive your medication history or if you are the parent or guardian of a child, please provide your consent for them as well. If you do not want your physician to receive this information, please indicate below that your consent is denied. Thank you for your help

Patient Name: _____
Patient DOB : _____

" I give my consent for my doctor to receive my complete medication history"

_____ _____
Patient Signature Date

"I do not give my consent for my doctor to receive my complete medication history"

_____ _____
Patient Signature Date

"I give my consent for my minor child's doctor to receive his/her complete medication history"

_____ _____
Parent/Guardian Signature Date

"I do not give my consent for my minor child's doctor to receive his/her complete medication history"

_____ _____
Parent/Guardian Signature Date

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