Northeast Tarrant Internal Med Assoc
479 Westpark Way
Euless, TX 76040-3957
USA
(817) 358-5500

PATIENT INFORMATION

NAME (Last, First Middle)		MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS	ETHNICITY

HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP	RACE

MARITAL STATUS	STUDENT STATUS ☐ Full-Time ☐ Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE	HOME PHONE

SEXUAL ORIENTATION	PREFERRED PRONOUN	GENDER IDENTITY	

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)		SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS ☐ Full-time ☐ Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT	
			$
CITY, STATE ZIP	PHONE	DEDUCTIBLE	
			$
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#
ADDRESS OF INSURANCE COMPANY			COPAY AMT
			$
CITY, STATE ZIP	PHONE		DEDUCTIBLE
			$
RELATIONSHIP TO PATIENT			EFFECTIVE DATE / EXPIRATION DATE

I authorize the release of any medical information required to process claims. I also authorize payment of medical benefits to the North East Tarrant Internal Medicine Associates if they choose to accept assignment.
It is customary to pay for services when rendered unless other arrangements have been made. I understand that I am financially responsible for all charges.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

Northeast Tarrant Internal Medicine Associates
469 Westpark Way
Euless, Texas 76040-3957
(817) 283-2888

Patient Confidentiality Questionnaire

Patient Name: _____ Date of Birth: _____

1. Please list the family member (with phone numbers) or other persons, if any, whom we may inform about your general medical condition or your diagnosis:

2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent, **if other than your home:**

4. Can confidential messages be left on your home answering machine or voicemail?

5. If you do not have voicemail, can a confidential message be left at your place of employment?

_____ _____
Patient Signature Date

Physical Exam Information

Dear Patient:

Our goal is to provide you with the best medical care possible. Annual physical exams give us a chance to address your overall physical and emotional health. The ***preventative*** care we provide during a physical also includes an *assessment of dietary and exercise habits, review of vaccinations, discussion of screening tests, lifestyle behaviors, etc.* We often look in on chronic stable problems such as high blood pressure, arthritis, and/or other ongoing medical conditions, though we don't always charge for that, depending on the degree of difficulty or amount of time spent.

Regular office visits differ from the ***preventative*** and wellness care provided at a physical because they address *other new ongoing or poorly controlled medical problems.* These types of problems need to be addressed in an appointment separate from a ***preventative*** or physical exam. If, however, we adequately cover required preventative and wellness care during the physical, sometimes we will have time to address other issues. You OR your doctor may identify an issue that may need to be addressed during a physical, ***separate from preventative care.***

We would like to attempt to correct a misperception that is occurring at times regarding "double charges". Our goal is to address as much as we can in a quality manner during visits. Please note that the insurance companies do allow providers to address additional complaints beyond a physical examination, if there is time. If additional problems are found or addressed, an additional office evaluation code will be generated in addition to a preventative physical examination code. We are required to submit billing in this fashion, if we address care beyond preventative care at the physical examination. *This essentially generates an extra charge to the insurance company for issues addressed beyond preventative care, which in turn may require you to pay additional copay, coinsurance or deductible charges.*

The coding rules set by the health care industry, specifically state, *"If an abnormality is encountered or a pre-existing problem is addressed in the process of performing this preventative medicine evaluation service, then the appropriate visit code should also be reported."* We can actually fail an audit if we violate these rules.

You have entrusted us with your medical care. Please also trust that we practice the highest integrity with our billing practices. Our goal is to provide excellent care and take appropriate time doing it. Please speak with your provider if you have any questions regarding the charges from your preventative care/physical today.

Sincerely,

Northeast Tarrant Internal Medicine Associates

PATIENT NAME: **DOB:**

2020 Annual Wellness Form

The following information is being collected today as part of an Annual Wellness Visit. We understand that some of this information may have already been communicated to the doctor, but we would like to ensure that we keep your medical records up to date. If you have any questions, please let us know.

Patient Name	Date of Birth	Physician Name	Today's Date

MEDICATIONS

List all medications including OTCs, vitamins/minerals, and dietary supplements including dosage, frequency, and route of administration

FAMILY HISTORY

	Father	Mother	Children	Sibling	Grandparents
Hypertension	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐

GENERAL HEALTH & HEALTH MANAGEMENT

In general, would you say your health is:	☐Excellent ☐Very Good ☐Good ☐Fair/Poor
In general, would you say your hearing is:	☐Excellent ☐Very Good ☐Good ☐Fair/Poor
Please describe the current condition of your mouth and teeth (including false teeth or dentures)?	☐Excellent ☐Very Good ☐Good ☐Fair/Poor
In the past 7 days, how much pain have you felt?	☐ None ☐Some ☐A lot
How confident are you that you can control and manage most of your health problems?	☐I do not have any health problems ☐Confident ☐Somewhat confident ☐Not Very Confident
Current physical activity as compared to last year is?	☐More ☐ Less ☐Same

LIST OF PHYSICIANS

Optometrist
OB/GYN
Ophthalmologist
Cardiologist
Gastroenterologist
Nephrologist
Oncologist

PATIENT NAME: **DOB:**

VACCINATION & IMMUNIZATIONS

Did you receive **last season's (Aug. 1, 2019-March 31, 2020)** Flu immunization?	☐ Yes ☐ No ☐ Declined ☐ Allergic _____ / ____ / _____ Month Day Year
Did you receive the **2019-2020 Flu Season immunization**? (Aug. 1, 2019 – March 31, 2020)	☐ Yes ☐ No ☐ Declined ☐ Allergic _____ / ____ / _____ Month Day Year
When was your last Tetanus shot?	☐ Yes ☐ No ☐ Declined ☐ Allergic _____ / ____ / _____ Month Day Year
Have you ever had a Shingles Vaccination?	☐ Yes ☐ No ☐ Declined
Have you ever had a Pneumonia Vaccination?	☐ Prevnar 13 _____ / ____ / _____ ☐ Pneumovax 23 _____ / ____ / _____ ☐ Yes, but I'm not sure of the type _____ / ____ / _____ ☐ No

DIAGNOSTIC HISTORY

Please complete the following section with as much information as possible. Leave a section blank, if the section does not apply to you or if you do not remember the information.

Colonoscopy	_____ / ____ / _____ Month / Day / Year	_____ Physician	☐ No Polyps ☐ Positive for Polyps ☐ Other Results ☐ Not Applicable due to total Colectomy or colorectal cancer
Diabetic Eye Exam	_____ / ____ / _____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results
Eye Exam	_____ / ____ / _____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results
Echocardiogram	_____ / ____ / _____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results
Dental Exam	_____ / ____ / _____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results
Bone Density	_____ / ____ / _____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results
Hepatitis C	_____ / ____ / _____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results
Prostate Exam	_____ / ____ / _____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results
FEMALES ONLY			
Last Mammogram	_____ / ____ / _____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results ☐ Not Applicable due to Bilateral mastectomy or 2 unilateral mastectomies
Pap Smear	_____ / ____ / _____ Month / Day / Year	_____ Physician	☐ Normal ☐ Abnormal Results

PATIENT NAME: **DOB:**

Depression Scale Screen: Please check the boxes that apply.				
Questions:		YES		NO
Are you basically satisfied with your life?				
Have you dropped many of your activities or interests?				
Do you feel that your life is empty?				
Do you often get bored?				
Are you in good spirits most of the time?				
Are you afraid that something bad is going to happen to you?				
Do you feel happy most of the time?				
Do you feel helpless?				
Do you prefer to stay at home, rather than go out and do things?				
Do you feel that you have more problems with memory than most?				
Do you think it is wonderful to be alive right now?				
Do you feel pretty worthless the way you are now?				
Do you feel full of energy?				
Do you feel that your situation is hopeless?				
Do you think that most people are better off then you are?				

TOBACCO / ALCOHOL/ OTHER ASSESSMENT	
Do you currently use any form of tobacco products?	☐ Yes ☐ No
If yes, how many years have you used tobacco products?	_____ years
What form of tobacco do you use?	☐ Cigarettes ☐ Cigars ☐ Chew ☐ Pipe ☐ E-Cig
If you do smoke, would you like to quit?	☐ Yes ☐ No
Do you drink alcoholic beverages?	☐ Yes ☐ No
How many per week?	☐ 10 or more ☐ 6-9 per week ☐ 2-5 per week ☐ I do not drink alcohol
Do you drink caffeine?	☐ Yes ☐ No # servings a day _____
Do you use sunscreen?	☐ Yes ☐ No
Do you use recreational drugs?	☐ Yes ☐ No

FALL RISK ASSESSMENT	
During the last 12 months, have you fallen 2 or more times?	☐Yes ☐No
During the last 12 months, have you had a fall that resulted in an injury?	☐Yes ☐No
Do you think that you are at high risk for falling?	☐Yes ☐No
Do you use any assistive devices such as a walker, wheelchair or cane?	☐Yes ☐No
Are you having trouble with walking or balance?	☐Yes ☐No
Do you require assistance getting up from a sitting position?	☐Yes ☐No

DIABETES CONTROL		
Do you have Type 1 or Type 2 Diabetes?		☐Yes ☐No
If yes, please report your most recent HbA1c level to your best knowledge:	_____ HbA1c level	_____ / _____ / _____ Date of screening

PAIN ASSESSMENT		
Are you experiencing any pain? Please rate your pain on a scale of 0-10	_____ Pain Level (1-10)	Location and description of pain : _____ _____

PATIENT NAME: **DOB:**

IVD AND STATIN

Are you taking ANY of the following medications Prasugrel (Effient), Aspirin, Clopidogrel (Plavix), Ticlopidine (Ticlid), Dipyridamole (Persantine), Ticagrelor (Brillinta)?	☐Yes ☐No
Are you taking a Statin?	☐Yes ☐No

ACTIVITIES OF DAILY LIVING

During the past 4 weeks, was someone available to help you if you needed and wanted help?	☐ No, Not at all ☐ Yes, Sometimes ☐ Yes, Always

In the past 4 weeks, have you had any trouble doing any of the following? If applicable, please list an individual who helped complete the task.

Take medications	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Getting around the home	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Bathing and Dressing	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Using the Telephone	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Traveling	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Grocery Shopping	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Preparing Meals	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Housework	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Managing Money	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Do you have a living will?	☐Yes ☐No
Do you have difficulty driving your car?	☐ No, difficulty ☐ Yes, sometimes ☐ No, I do not drive
Do you always fasten your seat belt when in a vehicle?	☐ Yes ☐ No
During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?	☐Heavy ☐Moderate ☐Light ☐Very Light
Do you exercise for 20 minutes, 3 or more days a week?	☐Yes, most of the time ☐Yes, some of the time ☐No, I do not exercise
Have you been given information to help you with the following: • Hazards in the home which may hurt you? • Keeping track of your medications?	☐ Yes ☐ No ☐ Yes ☐ No

Please indicate any of the following Chronic conditions that apply to you:

Chronic Condition	Date diagnosed	Managing Doctor	Date you last saw doctor	Today Physician Initials
Chronic Kidney Disease				
Cancer				
Coronary Artery Disease				
Depression/Anxiety				
Diabetes, (Type 1 or 2)				
DVT				
Genetic Disorder				
Heart Disease				
High Blood Pressure				
Liver Disease				
Osteoporosis				
Paraplegic/Quadriplegic				
Neurological Disorder				
Stroke				

PATIENT NAME: **DOB:**

Review of Systems: Check the box for symptoms you have or problems recurring in the last 6 months.

CONSTITUTIONAL:		**GENITOURINARY:**		**METOBOLIC/ENDOCRINE:**	
Chills	☐	Painful Urination	☐	Cold intolerance	☐
Fatigue	☐	Blood in Urine	☐	Heat intolerance	☐
Fever	☐	Increased Urination	☐	Increased thirst	☐
Malaise	☐	Urinary frequency	☐	Increased hunger	☐
Night sweats	☐	Urinary incontinence	☐	**PSYCHIATRIC:**	
Weight gain	☐	Urinary retention	☐	Anxiety	☐
Weight Loss	☐	**REPRODUCTIVE MALE:**	☐	Depression	☐
HEENT:		Erectile dysfunction	☐	Insomnia	☐
Eye discharge	☐	**REPRODUCTIVE FEMALE:**		**MUSKULOSKELETAL:**	
Eye pain	☐	Abnormal Pap	☐	Back pain	☐
Hearing loss	☐	Painful periods	☐	Joint pain	☐
Nasal drainage	☐	Pain with intercourse	☐	Joint swelling	☐
Sinus pressure	☐	Hot flashes	☐	Muscle weakness	☐
Sore throat	☐	Irregular menses	☐	Neck pain	☐
Visual changes	☐	Vaginal Discharge	☐	Contact allergy	☐
RESPIRATORY:		**NEUROLOGICAL:**		**HEMATOLOGIC/LYMPHATIC:**	
Chronic cough	☐	Dizziness	☐	Easy bleeding	☐
Cough	☐	Extremity numbness	☐	Easy bruising	☐
Known TB exposure	☐	Extremity weakness	☐	Swollen lymph nodes	☐
Shortness of breath	☐	Gait disturbance	☐	**IMMUNOLOGIC:**	
Wheezing	☐	Headache	☐	Contact allergy	☐
CARDIOVASCULAR:	☐	Memory loss	☐	Environmental allergies	☐
Chest pain	☐	Seizures	☐	Food allergies	☐
Claudication	☐	Tremors	☐	Seasonal allergies	☐
Edema	☐	**INTEGUMENTARY:**			
Palpitations	☐	Breast discharge	☐		
GASTROINTESTINAL:		Breast lump	☐		
Abdominal Pain	☐	Brittle Hair	☐		
Blood in stool	☐	Brittle nails	☐		
Change in stool	☐	Hair changes	☐		
Constipation	☐	Abnormal facial hair	☐		
Heartburn	☐	Hives	☐		
Nausea	☐	Itching	☐		
Vomiting	☐				

Patient Name _____ Date of Birth _____