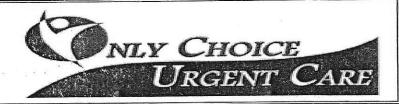
Jackie Wurtz, FNP Ruth Teague, FNP DJ Quality Care, LLC 11515 East FM 1960, Ste. C Huffman, TX 77336 Office: (281) 324-1550 Fax: (281) 324-1555

NEW PATIENT DEMOGRAPHICS

Name			DOB	
CONT ME				
Dago	Marital Status	_ Social Security # _		
Address	_ Phone	City/State _		
		Cell		
Employed? YE	S NO STUDENT Where?			Full time part
time				
Personal Ema	il		com	
What pharma	cy would you like to us	se?		
A 84 1				9 <sup>d</sup> 15
18 <del></del>	City			
Primary Insur	rance			
	=			
Group#				
Secondary In				
Subscriber ID#				
Diagnosis:				
-	-	<u> </u>		
Medication:				
Allergies:				
Previous Doc	tor's name			
Signature		Date	1 1	

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#### **MEDICATION REFILL POLICY:**

Refills for medication prescribed by your provider should be requested during your office visit. Request by phone will be addressed at our earliest convenience. Refills will not be approved after normal business hours, weekends or holidays.

Therefore, please call in your refill request in a timely manner to us directly or for the pharmacy to contact our office.

Refills for controlled substances require an office visit. No exceptions will be made.

### WE RESERVE AT LEAST 24 HOURS TO PROCESS ALL REFILL REQUEST.

PATIENT SIG	NATURE :	DATE:	-
ACKNOWLEDGEMENT OF RECEIP	T OF NOTICE OF PRIVACY	PRACTICES	
i acknowledge that the notice of Privacy Practices was	availiable and that I read (or	had the oportunity to read) and	
understa	nd the notice.		
Signature of Patient or Authotized Representative:			
Signature		Date	

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#### **Patient History**

**Have you ever been hospitalized?** (If there is not enough space provided, please continue on the other side of this form.)

• Family History	ar .	
Father: Alive / Deceased Mother: Alive / Deceased Brothers: Alive Deceased Sisters: Alive Deceased _ Sons: Alive Deceased Daughters: Alive Deceased _		
Social History		
Do You Smoke? Y N  If yes, how often?		
Have you smoked in the past? Y N  If yes, how often?		
Are you subject to second hand smoking? Y N If yes, how often?		
Do you drink alcohol? Y N  If yes, how often?		
Do you do Recreational drugs? Y N  If yes, how often?		
Do you drink caffeine? Y N  If yes, how often?		
Do you exercise? Y N  If yes, how often?  Please list any other information that may be helpful.		
		Name:
Date		

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### REQUEST FOR RELEASE OF MEDICAL RECORDS

DATE:
PATIENT:
DATE OF BIRTH:
SOCIAL SECURITY #:
This request is to allow records (including any and all tests and reports)
Γo be released to DJ. Quality Care, LLC from
Name of doctor or hospital)
From any legal responsibility or liability for the release of information on the above patient
PATIENT'S SIGNATURE:

Jackie Wurtz, FNP Ruth Teague, FNP DJ Quality Care, LLC 11515 East FM 1960, Ste. C Huffman, TX 77336 Office: (281) 324-1550

Office: (281) 324-1550 Fax: (281) 324-1555

### ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, you acknowledge that you have received/read the Notice of Privacy Practices of DJ. Quality Care, LLC.

Our Notice Practices explains how DJ Quality care, LLC may use and disclose you're protected health information for treatment, payment and healthcare options. Protected health information means your personal health information found in your medical and billing records.

Our Notice of Privacy Practices Information also contains additional general information regarding our practice operation and certain policy and procedures that may affect you.

### Your signature below acknowledges that you have received/read these notices.

Patient Name:	
Patient Signature:	
Date:	
Parent or Guardian Signature:	
Date:	

Jackie Wurtz, FNP Ruth Teague, FNP DJ Quality Care, LLC 11511 East FM 1960, Ste. 102 Huffman, TX 77336 Office: (281) 324-1550 Fax: (281) 324-1555

Designation for Release of Medical Information to a Family Member, Friend or Legal Representative

#### Introduction

It is the physicians' responsibility to ensure that the physician-patient relationship is Confidential. The Privacy Statement of DJ Quality care, LLC is the basis for how we treat your Protected Health Information. HIPAA allows physicians to use their professional judgment on disclosing certain PHI to family, friends, etc. without an authorization. This form is an aid to the physicians in making a determination on disclosing such information. DJ Quality Care, LLC realizes there are times when you, the patient, may want another person to be knowledgeable about your medical condition or medical needs. Your doctor wants you to be able, if you so desire, to name a person (s) to whom you want the office staff to speak with about your medical condition. To enable that, we would ask that you complete the form listed below. Please note the following points:

- Only 3 people can be designated for this role
- The designation is valid until you cancel it in writing
- If you designate no one, DJ Quality Care, LLC may not be able to release information to any family member or friend.

### **Designation Statement** I, \_\_\_, designate the following person (s) to be able to speak to a physician at DJ Quality Care, LLC, a nurse or other staff member, should it be necessary, on my behalf. I hereby give permission to DJ Quality Care, LLC through its physicians and staff to release to my designee any information about my medical condition or medical needs or the status of my account and I release DJ Quality Care, LLC, its physicians and staff from any claim of confidentiality in connections with the release of this information. Name of Designated Person: \_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_ Phone Number (home/work) Name of Designated Person: Phone Number Relationship: (home/work) Name of Designated Person: \_\_\_\_\_ Phone Number \_\_\_\_ (home/work) Patient's Signature: Date: Witness: I decline to designate another person to speak with my physician or clinical staff. Patient's Signature: Witness: Date: