*North Dallas Internal Medicine*
*8210 Walnut Hill Ln. Ste 812 Dallas, TX 75231*
*Phone: 214-696-1118 Fax: 214-696-4447*

## Patient Information

First Name:_____ MI:_____ Last Name_____
SSN:_____-_____-_____ Date of Birth:_____ Sex: ___M ___F
Address:_____ City:_____ State:____ Zip:_____
Home Phone Number:(____)_____-_____Cell Phone Number:(____)_____-_____
Email Address:_____
Emergency Contact:_____ Relationship:_____ Phone Number:_____
Employer and Employer's Address:_____
Occupation:_____ Work Phone:(____)_____-_____

## Responsible Party Information

If patient is the responsible party mark self and go down to insurance information.

Patients relationship to responsible party: ____Self ____Spouse ___Dependant

First Name:_____ MI:____ Last Name:_____
SSN:_____-_____-_____ Date of Birth:_____ Sex: ___M ___F
Address:_____ City:_____ State:____ Zip:_____
Home Phone Number:(____)_____-_____Cell Phone Number:(____)_____-_____
Employer and Employer's Address:_____
Occupation:_____ Work Phone(____)_____-_____

## Primary Insurance Information

Insurance Company_____ Phone:_____
Claim Address:_____ City:_____ State:_____ Zip:_____
Subscriber ID:_____ Group Policy Number:_____
Effective Date:_____ Co-payment:_____

## Assignment and Release

Hereby assign, transfer and ser over to Dr. Jeb S. Miers all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine those benefits. This authorization will remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for any balances not covered by insurance carrier.

Patient Signature:_____ Date:_____

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# Notice of Privacy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED ADN HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT AND CAREFULLY

**Uses and disclosures of health information**. We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Information mat be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements we may give out health information with out your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask you for written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclosure information, you can later revoke that authorization to stop any future uses and disclosures. We may change our policies at any time. Before we make a significant change in our policies, we will change of notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practice, contact the person listed below.

**Individual rights**. In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you only normal photocopy fees. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes and other than when you explicit authorized it. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Complaints: If you are concerned that we have violated your privacy rights, or below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

**Our legal duty.** We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and obtain your acknowledgement of receipt of this notice.

*If you have any questions or complaints, please contact:*
*Office Manager: Ruthann Moseley*

Please sign your name and print your name and date on this acknowledgement form. Return signed acknowledgement to the receptionist.

Signature:_____

Printed Name:_____ Date:_____

North Dallas Internal Medicine Patient Update:

Please take the time to fill out the questionnaire and update.
It will allow us to better serve you. Your time is greatly appreciate.

Name:_____ Date:_____

Reason for this visit:

_____
_____

History of Illnesses of Diseases:

_____
_____
_____

What medications are you currently taking?

_____
_____
_____

What are you allergic to?

_____
_____

Have you seen another doctor or provider in the past 5 years or since being seen?_____
Please list names and city of practices if not in Dallas.

| Have you had appropriate preventative care? | Yes | No | Please Explain: |
|---|---|---|---|
| For Ladies>21 Pap smear and yearly examinations | ____ | ____ | _____ |
| >40 then Yearly mammograms | ____ | ____ | _____ |
| For Man >40 Yearly prostate examination and PSA | ____ | ____ | _____ |
| Colonoscopy if >50 years of age | ____ | ____ | _____ |
| Influenza Vaccination if >65 or special population | ____ | ____ | _____ |
| Pneumonia vaccination by age 65? | ____ | ____ | _____ |
| Tetanus toxoid booster? | ____ | ____ | _____ |

Have you had good or bad experiences at this office, hospital or any other?____

Please explain, if this office then be specific please.

# Review of Systems

| Constitutional | Presence: Yes-No | Notes: |
|---|---|---|
| Weight Gain | | |
| Loss of Appetite | | |
| Fever | | |
| Weakness | | |
| Bleeding Problems | | |
| Which Lost | | |

| Dermatology | Presence: Yes-No | Notes: |
|---|---|---|
| Rash | | |
| Changing Color of Moles | | |
| Lumps | | |
| Dry or Sensitive Skin | | |
| Hives | | |

| Endocrinology | Presence: Yes-No | Notes: |
|---|---|---|
| Fatigue | | |
| Excess of Sweating | | |
| Excessive Thirst | | |
| Excessive Urination | | |
| Weight Loss | | |
| Sleep Disturbance | | |
| Cold Intolerance | | |

Heat Intolerance

| **Neurology** | **Presence: Yes-No** | **Notes:** |
|---|---|---|
| Headache | | |
| Tingling Numbness | | |
| Seizures | | |
| Insomnia | | |
| Memory Loss | | |
| Dizziness | | |

| **Ophthalmology** | **Presence: Yes-No** | **Notes:** |
|---|---|---|
| Diminished Vision | | |
| Eye Irritation | | |
| Drainage from the eye | | |
| Blurring of Vision | | |
| Seasonal Eye Symptoms | | |
| Dander Eye Symptoms | | |

| **Respiratory** | **Presence: Yes-No** | **Notes:** |
|---|---|---|
| Shortness of Breath | | |
| Chest Pain | | |
| Bronchitis | | |
| Asthma | | |
| Cough | | |
| Bloody Sputum | | |
| Pleurisy | | |

Inability to catch one's breath

Blue Discoloration of skin

| **Allergy** | **Presence: Yes-No** | **Notes:** |
|---|---|---|
| Runny Nose | | |
| Scratchy Throat | | |
| Itchy Eyes | | |
| Ear Fullness | | |
| Sinus Congestion | | |
| Stuffy Nose | | |

| **Hematology Lymphatic** | **Presence: Yes-No** | **Notes:** |
|---|---|---|
| Swollen Glands | | |
| Fatigue | | |
| Loss of Appetite | | |
| Varicose Veins | | |
| Excessive Bleeding | | |

| **Urology** | **Presence: Yes-No** | **Notes:** |
|---|---|---|
| Difficulty Urinating | | |
| Blood in Urine | | |
| Urinary Urgency | | |
| Frequent Urination | | |
| Urinary Incontinence | | |
| Voiding Dysfunction | | |
| Fecal incontinence | | |

Pain with Sex

Recurrent Urinary Tract Infections

Urinating at night to much

## Ear, Nose, and Throat **Presence: Yes-No** **Notes:**

Cold

Cough

Coughing blood

Nosebleed

Hearing Loss

Change in voice

Sore Throat

Ringing in Ears

Snoring

## Cardiology **Presence: Yes-No** **Notes:**

Dizziness

Chest pain

Palpitations

Leg Swelling

Shortness of breath

Varicose Veins

## Gastroenterology **Presence: Yes-No** **Notes:**

Nausea

Heartburn

Vomiting

Bloating/Belching

Difficulty Swallowing

Abdominal Pain

Diarrhea

Constipation

Change in Bowel Habits

Blood in Stool

## Musculoskeletal **Presence: Yes-No** **Notes:**

Joint Stiffness

Leg Cramps

Joint Pain

Joins Welling

## Psychology Psychiatry **Presence: Yes-No** **Notes:**

Depression in

High stress Level

Sleep Disturbance

Respiratory Symptoms worse with stress

Suicidal Ideation

Eating Disorder

# Family Medical History

| Family members | Status: | Age: | Notes: |
|---|---|---|---|
| **Father** | | | |
| Father | _____ | _____ | _____ |
| Maternal Uncle | _____ | _____ | _____ |
| Maternal Aunt | _____ | _____ | _____ |
| Paternal Uncle | _____ | _____ | _____ |
| Paternal Aunt | _____ | _____ | _____ |
| **Mother** | Status: | Age: | Notes: |
| Mother | _____ | _____ | _____ |
| Paternal Grandfather | _____ | _____ | _____ |
| Paternal Grandmother | _____ | _____ | _____ |
| Maternal Grandfather | _____ | _____ | _____ |
| Maternal Grandmother | _____ | _____ | _____ |
| **Siblings** | Status: | Age: | Notes: |
| Brothers | _____ | _____ | _____ |
| Sisters | _____ | _____ | _____ |
| **Children** | Status: | Age: | Notes: |
| Sons | _____ | _____ | _____ |
| Daughters | _____ | _____ | _____ |

# Social History

| | Yes | No | Notes |
|---|---|---|---|
| Smoking | _____ | _____ | _____ |
| Recreational drug use | _____ | _____ | _____ |
| Exercise | _____ | _____ | _____ |
| New Since Last Visit | _____ | _____ | _____ |
| Alcohol | _____ | _____ | _____ |
| Sexual Activity | _____ | _____ | _____ |
| Travel | _____ | _____ | _____ |
| Occupation | _____ | _____ | _____ |
| Occupation Exposures | _____ | _____ | _____ |