PATIENT INFORMATION

CONFIDENTIAL

(PLEASE PRINT CLEARLY)

LAST NAME _____FIRST NAME_____ MI____ BIRTHDATE_____ ❒ M or ❒ F

SS #_____-_____-_____ CHECK ONE: ❒ Minor ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

ADDRESS_____CITY_____ST_____ZIP _____

HOME PHONE ( )_____ CELL # ( )_____ WORK # ( ) _____

e-MAIL _____ OCCUPATION: _____

PATIENT'S EMPLOYER_____ Full-Time / Part-Time / Retired

SPOUSE OR PARENT'S NAME_____

EMPLOYER_____ WORK PHONE ( ) _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____CITY_____ST____ ZIP _____

HOW DID YOU HEAR ABOUT THIS CLINIC?
❒ Friend/Family ❒ Telephone Book ❒ Newspaper Ad ❒ Internet ❒ Referred by Dr. _____ ❒ Other _____

EMERGENCY CONTACT

NAME_____ PHONE ( ) _____ RELATIONSHIP PATIENT _____

ADDRESS _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____RELATIONSHIP PATIENT _____

DOB: _____ SS #_____-_____-_____ HOME PHONE ( )_____CELL # ( ) _____

ADDRESS, CITY, ST, ZIP _____

EMPLOYER _____WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? Yes or No

INSURANCE INFORMATION

Please bring your Photo ID and Insurance Card(s) for your appointment.

We will scan your ID and insurance information in to your chart:
We are located at:

MYRNA C. DE ASIS, M.D.
1819 10TH ST
WICHITA FALLS, TX 76301
TEL (940) 763-8077
FAX (940) 763-8078
www.DeAsisMD.com

ALL SERVICES ARE PAYABLE IN FULL UNLESS ARRANGEMENTS ARE MADE IN ADVANCE.

I authorize release of any information concerning my (or my child's) health care, advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to Dr. De Asis. I fully understand that whatever my insurance does not cover or pay, I am responsible for the payment of the medical service/procedure. I hereby permit Dr. De Asis to render medical/surgical treatments to the above named patient. Dr. De Asis does not guarantee any treatment outcome or cures.

_____ _____
Signature of patient or parent if minor Date

Myrna C. De Asis, M.D., P.A.

Comprehensive Patient History

Patient Name: _____ M / F Age: ____ Date of Birth: _____ Date: _____
Last Name, First Name

What is the reason for today's visit? _____

Describe the following:

Location: _____ How long have you had this problem? _____

How severe is this problem? ❒ mild ❒ moderate ❒ very How often are you having the problem? _____

What caused this problem? _____

Do you know of anything else that may have contributed to this problem? _____

Does anything else occur with this problem? _____

Additional Comments:

_____

List previous hospitalizations/Surgeries/Serious Injuries When?

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Patient Social History

Marital Status ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed

Use of alcohol: ❒ Never ❒ Rarely ❒ Moderate ❒ Daily _____

Use of tobacco: ❒ Never ❒ Quit when_____ ❒ Current packs per day _____

Use of Drugs: ❒ Never ❒ Type/Frequency _____

Excessive exposure at home or work to: ❒ Fumes ❒ Dust ❒ Solvents ❒ Noise

List any allergies you have.

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____
10) _____

Have you ever had the following?

Cancer	Yes	No	Diabetes	Yes	No	Hypertension	Yes	No
Arthritis/Gout	Yes	No	Stroke	Yes	No	Heart trouble	Yes	No
Acute Infections	Yes	No	Convulsions	Yes	No	Bleeding Tendency	Yes	No
			Venereal Disease	Yes	No	Hereditary Defects	Yes	No

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____

Personal / Social History *(To be filled out by physician)*

_____
_____
_____
_____
_____

COMPREHENSIVE HISTORY

Have you experienced any of the following in the last 6 months?

PLEASE ANSWER ALL QUESTIONS

CONSTITUTIONAL — Date

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

EYES

Eye disease or injury	No	Yes
Wear glasses/contact lens	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes

ENT

Hearing loss	No	Yes
Ringing in the ears	No	Yes
Earaches or drainage	No	Yes
Sinus problems	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

CARDIOVASCULAR

Heart trouble	No	Yes
Chest pains	No	Yes
Sudden heart beat change	No	Yes
Swelling of feet, ankles or hands	No	Yes

RESPIRATORY

Frequent coughing	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

GASTROINTESTINAL

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements or constipation	No	Yes
Blood in stool	No	Yes
Stomach pain	No	Yes

GENITOURINARY

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change of force of strain when urinating	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Male – testicle pain	No	Yes

Male – last prostate exam? _____

Female – pain with periods	No	Yes
Female – irregular periods	No	Yes
Female – vaginal discharge	No	Yes

Female – # pregnancies ____ # miscarriages ____ # abortions ____

Female – date of last pap smear _____

Female – findings of last pap smear ❒Normal ❒Abnormal

Female – last mammogram _____ Where? _____

MUSCULOSKELETAL — Date

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

SKIN

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

NEUROLOGICAL

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes

PSYCHIATRIC

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Sleep problems	No	Yes

ENDOCRINE

Glandular or hormone problem	No	Yes
Thyroid disease	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Dry skin	No	Yes
Change in hat or glove size	No	Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	No	Yes
Easily bruise or bleed	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

_____

_____

_____

_____

_____

_____

_____

_____

_____

ADDITIONAL NOTES

MYRNA C. DE ASIS, M.D.

Patient Last Name, First Name _____ **Date of Birth** _____

	MOST RECENT							
EKG								
Hemoglobin A1C								
Eye Exam								
Pap Smear								
Mammogram								
Bone Density								
Prostate								
PSA								
Hemocult								
Colonoscopy								
Endoscopy								
VACCINE								
Influenza								
Pneumococcal								
Shingles								
Tetanus Booster								
PPD								

SCREENING & PREVENTIVE SERVICES

MYRNA C. De ASIS, MD

MEDICATION LIST

LNAME, FNAME, MI.	Date of Birth
ALLERGIES	

Medication / Dose	How Often	Prescribing Physician

MEDICATION LIST

MYRNA C. De ASIS, M.D., P.A.

Internal Medicine

Medical Information Release Form

(HIPAA Release Form)

Patient Name: _____ **Date of Birth:** _____

e-mail: _____

Race: (Please select)
White | Black/African American | Asian | American Indian/Alaska Native | Native Hawaiian | Other Pacific Islander | More than one race | Unreported/Refused to report

Ethnicity: (Please select)
Hispanic/Latino | Non-Hispanic/Latino | Unreported/Refused to report

Language:
Please indicate primary language: English | Spanish | Other _____

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

❒ Myself Only
❒ Designate one person (Optional) _____
Relationship: ❒ Spouse ❒ Son/Daughter ❒ Parent ❒ Other _____

This Release of Information will remain in effect until terminated by me in writing.

Preferred Method of Contact

Indicate all that applies in order of preference:
❒ Home Phone ❒ Cell Phone ❒ Work Phone ❒ DO NOT CALL

If unable to reach me:
❒ You may leave a detailed message
❒ Please leave a message to call the office
❒ Do not leave a message
❒ Other

HIPAA Policy
I have been given the opportunity to read our policy on Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L.104-191), which is available in print, or on our website at www.DeAsisMD.com.

Signed: _____ Date: _____

Witness: _____ Date: _____

MYRNA C. De ASIS, M.D., P.A.

Internal Medicine
1819 10th Street, Wichita Falls, TX 76301
Tel. (940) 763-8077
Fax (940) 763-8078
www.DeAsisMD.com

POLICY GUIDELINES

Welcome to our clinic. Dr. De Asis is committed to your care as a specialist in internal medicine. We accept patients starting at 16 years old. As a primary care physician, Dr. De Asis will also coordinate your other medical needs outside the scope of internal medicine and will refer you to other medical specialties based on medical necessity.

INITIAL OFFICE VISIT
Please bring your completed New Patient Forms with you on your first visit. Additional copies of the forms can be downloaded from our website www.DeAsisMD.com. You also need to bring all your prescription bottles with you, so we can accurately document all your medications. In addition, you need to present your insurance card(s) and a government issued photo ID.

SUBSEQUENT VISITS
We will schedule your follow-up visits, as needed. In the event that you need to visit with Dr. De Asis for a non-emergency condition that can be handled in the office, please call us for an appointment and we will do our best to accommodate your schedule. Please present your insurance card(s) at every visit and inform our staff of any changes (name, address, telephone, cell number, place of employment, insurance policy, etc.) so we may update your records accordingly.

EMERGENCIES
During a true emergency, dial 911 or have someone take you to the hospital emergency room immediately. Dr. De Asis or the physician on call will be contacted by the hospital staff.

MISSED APPOINTMENTS
Our office requires a 24-hour notice if you need to cancel or reschedule your appointment. We understand that time is very valuable to all of us and there are times when the unexpected happens and we will take that into consideration. Otherwise, effective as of July 1, 2007, there will be a $25 charge on your account for every missed appointment. We hope that this policy will cut down on unnecessary missed appointments that could have been used by another patient who needed medical care.

PRESCRIPTIONS
Please call in your request for prescription refills at least 3 days in advance to avoid any delay and interruption of your medications. Do not wait until you are out of your medication before you call. To expedite your routine refills, ask your pharmacist to fax the request to our office. For your safety and in compliance medically accepted principles, antibiotics can not be prescribed unless the patient is examined by the physician; and are not refillable. Similarly, prescribed narcotics, such as pain medications, are controlled substances regulated by the state and federal governments. These medications will not be refilled until they are due and under the sole medical judgment of the physician.

MEDICAL SAMPLES
Due to limited supply, medication samples will be dispensed only to patients who are in the office for treatment (based on availability).

CONSULTS or SECOND OPINIONS
Medical care is very complex and diverse in nature and as such, no one medical practitioner can meet all your medical needs. If you feel that you need to consult with another specialist or seek a second opinion, please discuss this with the physician. We may be able to assist you in referring you to another caregiver, either as a request for consultation or a transfer of care. Should you decide to seek medical care from another primary care physician, upon receipt of your signed Medical Records Release form, we will transfer your medical records to the physician you designate.

MEDICAL RECORDS & SPECIAL REPORTS
Under Section 165 – 165.5 of the Texas Medical Boards, practitioners may charge for copies of medical records, special reports, additional insurance forms, letters, et. al, unless specifically excluded by statute. The current rate for the preparation and reproduction of a medical record is $25 for the first 20 pages, and 50 cents for each additional page.

AFTER-HOUR CALLS
Please limit after-hour calls to problems that can not wait until the next business day. After-hour calls are answered by our answering service and directed to the physician on-call at that time. Pain medications and routine prescriptions can not be authorized after hours. All emergencies should be directed to the nearest emergency room or by calling 911.

HOSPITAL AFFILIATIONS
United Regional Health Care System (URHCS)

INSURANCE
We accept most major insurance in the area, including Medicare, Medicare Advantage Plans, Blue Cross/Blue Shield, Aetna, Humana, CIGNA, Health Smart, United Healthcare, Multiplan and PCHS Network, Medicaid as secondary to Medicare, and many others. As a general guideline, please contact your specific plan before making an appointment with any provider or facility so that you can avoid incurring additional cost for going to an "out-of-network" provider. Please talk to our staff if you have any questions.

PRACTICE EXCLUSIONS
Due to practice volume constraints, this clinic no longer accepts the following: Disability determination, nursing home, workers compensation, and motor vehicle or other liability claims.

TERMINATION OF PATIENT-PHYSICIAN RELATIONSHIPS
We treat all our patients with the utmost compassion, respect and dignity. We also expect our staff to strive for the highest professional and ethical standards in patient care. However, there are times, when it is in the best interest of all concerned that we will terminate a patient-physician relationship and ask the patient to seek medical care at another facility In accordance with the Texas Medical Boards, with proper notification, a provider may terminate a patient-doctor relationship under certain circumstances when a patient is, but not limited to: disrespectful and threatening to the staff or other patients, disruptive in the office, non-compliant with physician's orders or medications, combative or belligerent, abusive, or fails to take responsibility of his/her financial obligations. Aforementioned examples are not all-inclusive and all such terminations will be done in compliance with the guidelines as set forth by Texas statutes.

FINANCIAL RESPONSIBILITY
In an ongoing effort to keep the cost of medical care down, we ask our patients to take full responsibility for their financial obligations in their medical care. Please help us by paying your copays, deductibles, and co-insurance at the time of each visit. You can also help by sending in your payments if there is any balance due after your insurance(s) have adjudicated your claims. If you think that your medical insurance claims have not been settled to your satisfaction, call your insurance company immediately. You pay a premium to maintain your health insurance coverage, and if you are not getting the benefits you paid for, you have the right to know. For assistance, you may also contact the Texas Department of Insurance at (800) 252-3439 or www.tdi.state.tx.us. Should you have any questions regarding your account with us, please talk to our staff and we will do our utmost to assist you.

COLLECTION POLICY
Accounts that are 90 days past due are considered delinquent and will be forwarded to our legal counsel for collection, unless you make financial arrangements with our office. We will make all reasonable attempts to settle outstanding accounts and use our legal counsel as a last resort. We are here to help. Please discuss any financial issues with our staff.

RETURNED CHECKS
A $25.00 fee will be assessed for checks that are returned for insufficient funds. Unpaid checks will be turned over the Wichita County District Attorney's office for further action, as permitted by law.

I have read and understand the Policy Guidelines of this office.

_____	_____	_____	_____
Patient or Guardian (Print)	Relationship to Patient	Signature	Date

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____ Medical Record # _____

Date of Birth _____ Social Security # _____(optional)

I authorize the following individual or organization to disclose the above named individual's health information:

From:

_____

_____

_____

To:

MYRNA C. DE ASIS, M.D.
1819 TENTH STREET
WICHITA FALLS, TX 76309
TEL. (940) 763-8077
FAX (940) 763-8078

Purpose or Need for Disclosure:

___ Continued Patient Care
___ Personal Use
___ Attorney/Legal
___ Insurance Claim/Application
___ Disability Determination
___ Other (Specify)_____

Please release the following:

___ Problem List
___ Progress Notes
___ History/Physical Exam
___ Medication List
___ Immunization Records
___ List of Allergies
___ X-Ray/Imaging Reports-from (date) _____ to (date) _____
___ X-Ray Films
___ Laboratory Results-from (date) _____ to (date) _____
___ EKG Reports
___ Genetic Testing Information
___ Other Diagnostic Reports (Specify) _____
___ Other (Specify) _____

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:
_____.

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFT 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness