## 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 _____

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

PHOTO COPY FRONT AND BACK OF INSURANCE CARD(S) AND ATTACH HERE,
OR USE A SEPARATE SHEET AS NEEDED.

**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)*

_____
_____
_____
_____
_____

**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 |

***List all medications you are now taking.***

_____
_____
_____
_____
_____
_____
_____
_____
_____

**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 | | | | | | | | |
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**SCREENING & PREVENTIVE SERVICES**

**MYRNA C. De ASIS, MD**

## MEDICATION LIST

| LNAME, FNAME, MI. | Date of Birth |
|---|---|
| ALLERGIES | |

| Medication / Dose | How Often | Prescribing Physician |
|---|---|---|
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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