Northwest Diagnostic

Patient Health History Questionnaire

Patient Name _____ Date of Birth ___/___/_____ Primary Care Provider _____ Today's Problem _____

Medical History

(List all diagnosed problems, hospitalizations, injuries)

Date	Item
___/___/_____	_____
___/___/_____	_____
___/___/_____	_____
___/___/_____	_____
___/___/_____	_____
___/___/_____	_____
___/___/_____	_____
___/___/_____	_____
___/___/_____	_____

Surgical History

___/___/_____ _____
___/___/_____ _____
___/___/_____ _____
___/___/_____ _____
___/___/_____ _____
___/___/_____ _____

OB/GYN History

Pregnancies: ___ Term: ___ Preterm: ___
Miscarriages: ___ Living Children: ___
Age of 1st Period: ___ ○ regular ○ irregular
Last Menstrual Period: ___/___/_____

Cancer Screening History

(Please provide date of the most recent testing)

Pap Smear: ___/___/_____
Mammogram: ___/___/_____
Colonoscopy: ___/___/_____

Social History and Habits

Marital: ○ Single ○ Married ○ Separated ○ Divorced ○ Widowed
Occupation: _____
Special diet: _____
Hobbies/Activities/Exercise: _____
_____
Alcohol: ○ never ○ quit on __/___/_____ ○ drinks/wk: ___
Tobacco: ○ never ○ quit on __/__/___ ○ packs/d: __ for __ yrs
Street Drugs: ○ never ○ use/have used: _____

Medications

(Include herbals, supplements, etc)

Name	Dose/Frequency
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Drug Allergies

Name	Reaction
_____	_____
_____	_____
_____	_____

Family History

(Ages, illnesses, living/deceased for each immediate family member; significant illnesses for extended family)

Mother: _____
Father: _____
Children: _____
Siblings: _____
Other: _____

Patient or Guarantor Signature: _____ Date: ___/___/_____
Provider Signature: _____ Date: ___/___/_____

Northwest Diagnostic

Patient Information

Please fill out the following patient information completely. Thank You.

_____ _____ ____ _____ ○ M ○ F ____/____/_____
Legal Last Name | Legal First Name | M.I. | Nickname | Gender | Date of Birth

_____ _____ _____ _____ _____-_____-_____
Street Address | City | State | Zip | Social Security #

(_____)_____-_____ (_____)_____-_____ (_____)_____-_____ x _____ ○ H ○ C ○ W
Home Phone # | Cell Phone # | Work Phone # | Ext | Primary #

_____ _____ ○ S ○ M ○ D ○ W _____ _____
Driver's License # | E-mail Address | Marital Status | Race | Ethnic Group

_____ (_____)_____-_____ _____
Pharmacy Name | Pharmacy Phone # | Pharmacy Location

Are you a new patient? ○ Y ○ N Is this a work related injury? ○ Y ○ N Is this visit due to an accident? ○ Y ○ N

How did you hear about us? ☐ Google ☐ Angie's List ☐ Personal Referral ☐ Print Ad ☐ Other: _____

☐ Employed (○ Full ○ Part ○ Self) ☐ Student (○ Full ○ Part) ☐ Retired ☐ Active Military Duty

_____ _____ _____
Employer | Position/Title | Employer's Street Address

_____ _____ ____ _____ (_____)_____-_____
Emergency Contact Last Name | First Name | M.I. | Relation to Patient | Emergency Contact Phone #

Do you have medical insurance? ○ Yes ○ No If yes, please complete the section below completely.

Primary Medical Insurance and Policy Holder Information

_____ _____ _____ ○ PPO ○ HMO ○ POS ○ MDC ○ EPO
Primary Insurance Company | Policy/Identificaton # | Group # | Plan Type

$_____ ____/____/_____ (_____)_____-_____ _____ _____ ____ _____
Copay | Effective Date | Benefits Phone # | Claims Address | City | State | Zip

_____ _____ ____ _____ ○ M ○ F ____/____/_____
Policy Holder Legal Last Name | Legal First Name | M.I. | Relation to Patient | Gender | Date of Birth

_____ _____ _____ _____ _____-_____-_____
Street Address | City | State | Zip | Social Security #

(_____)_____-_____ (_____)_____-_____ (_____)_____-_____ x _____ ○ H ○ C ○ W
Home Phone # | Cell Phone # | Work Phone # | Ext | Primary #

_____ _____ _____
Employer | Position/Title | Employer's Street Address

IF YOU HAVE SECONDARY INSURANCE, COMPLETE THE REVERSE SIDE OF THIS PAGE.

I request that payment of authorized insurance benefits be made on my behalf to Northwest Diagnostic Clinic for any services furnished. I authorize Northwest Diagnostic Clinic to release to the insurance company listed above any medical information about me or my dependent which may be needed to determine these benefits or the benefits payable for related services; this may be sent via written or electronic record. A photocopy of this assignment is to be considered as valid as the original until revoked. I understand that I am financially responsible for all charges whether or not covered by insurance. In addition, I am hereby notified that if I do not show for a scheduled appointment or fail to cancel an appointment, a no show will be noted on my account, and I will be charged a fee of $25.00. The clinic requires a 24-hour notice for all cancellations or reschedules. With three no shows, I may be terminated from the practice. I understand that this office holds my medical records in strict confidence. They will not be released to anyone without my explicit written permission. All requests for the release of medical records must be in writing. A reasonable fee may be charged for the compilation of medical records.

_____ _____ ____/____/_____
Patient or Guarantor** Signature | Guarantor Name | Date

****Guarantor is the adult who completes this form and is responsible for payment. If the guarantor is different from the insurance policy holder, please complete the guarantor information section on the reverse side of this page.**

Northwest Diagnostic

Guarantor Information

Guarantor is the adult who completes this form and is responsible for payment.

_____ _____ ____ _____ ○ M ○ F ____/____/_____
Legal Last Name | Legal First Name | M.I. | Relation to Patient | Gender | Date of Birth

_____ _____ _____ _____ _____-_____-_____
Street Address | City | State | Zip | Social Security #

(_____)_____-_____ (_____)_____-_____ (_____)_____-_____ x _____ ○ H ○ C ○ W
Home Phone # | Cell Phone # | Work Phone # | Ext | Primary #

_____ _____ ○ S ○ M ○ D ○ W
Driver's License # | E-mail Address | Marital Status

☐ Employed (○ Full ○ Part ○ Self) ☐ Student (○ Full ○ Part) ☐ Retired ☐ Active Military Duty

_____ _____ _____
Guarantor's Employer | Position/Title | Employer's Street Address

Secondary Medical Insurance and Policy Holder Information

_____ _____ _____ ○ PPO ○ HMO ○ POS ○ MDC ○ EPO
Secondary Insurance Co. | Policy/Identificaton # | Group # | Plan Type

$_____ ____/____/_____ (_____)_____-_____ _____ _____ ____ _____
Copay | Effective Date | Benefits Phone # | Claims Address | City | State | Zip

_____ _____ ____ _____ ○ M ○ F ____/____/_____
Policy Holder Legal Last Name | Legal First Name | M.I. | Relation to Patient | Gender | Date of Birth

_____ _____ _____ _____ _____-_____-_____
Street Address | City | State | Zip | Social Security #

(_____)_____-_____ (_____)_____-_____ (_____)_____-_____ x _____ ○ H ○ C ○ W
Home Phone # | Cell Phone # | Work Phone # | Ext | Primary #

_____ _____ _____
Employer | Position/Title | Employer's Street Address

_____ ____/____/_____
Patient or Guarantor Signature | Date

Northwest Diagnostic

Consent for Treatment

I am presently requiring diagnostic, medical or surgical treatment and do hereby voluntarily consent to such procedures and care and to such medical, surgical or other services under the general and specific instructions of Northwest Diagnostic Clinic, his/her assistants or his/her designee as is necessary in his/her judgment. I also acknowledge that the practice of medicine is not an exact science and that Northwest Diagnostic Clinic has made no guarantees to me as to the result of treatments or examination.

_____	_____	___/___/_____
Patient or Guarantor Signature	Patient Name	Date

Financial Policies

Our staff participates with many different types of insurance coverage. You are responsible for supplying us with a current insurance card and your copay before your visit. If you do not have these with you, it will be necessary for you to pay in full at your visit. Coinsurance and any deductibles will be billed to you at the address on file upon receipt of payment from your insurance company.

You are responsible for understanding the limitations of your policy. If you do not understand your policy, please call your insurance company and speak with a customer service representative.

We file with your insurance company promptly with each visit and allow 60 days for them to remit payment to this office. Should they not respond in the contract payment time frame, deny your claim or fail to pay a portion of the charges, you will be expected to make full payment to this office within 10 days of their response or 60 days from the billing date. You will be responsible for receiving an explanation of benefits from your insurance company.

Medicare Policy Holders

If you are a Medicare participant you are required to furnish us with your Medicare card. As a participating provider, we accept assignment on Medicare claims and allow 45 days for them to remit payment in full to this office. Should they not respond, deny your claim or fail to pay a portion of the charges, you will be expected to make full payment to this office within 10 days of their response or 45 days from the billing date. You will be responsible for receiving an explanation of benefits from Medicare. As a courtesy to you, if you have a secondary insurance carrier and provide us with a current insurance card at the time of service, we will gladly file the secondary claim for you. If your secondary does not remit payment within 30 days, the balance is your full responsibility and due at such time.

Private Pay

Payment in full will be required for each visit before you leave. You will be provided with a detailed itemization of charges at the time of payment for your visit.

I understand that I am financially responsible for all charges whether or not covered by insurance.

_____	_____	___/___/_____
Patient or Guarantor Signature	Patient Name	Date of Birth
_____	_____	___/___/_____
Guarantor Name	Relation to Patient	Date

Northwest Diagnostic

Policy Information

Welcome to Northwest Diagnostic Clinic! In order to ensure that all our patients understand our policies, please read the following policy information carefully. Afterward, **initial and sign where indicated**. You may request a copy to keep for future reference. Thank you.

_____ (initial) No Show/Late Cancellation

It is your responsibility to arrive for a scheduled appointment at the requested time. Effective August 1st, 2004, if you do not show or fail to cancel your appointment, a no show will be noted on your account and you will be charged a fee of $25.00. The Clinic requests 24 hour notice for all cancellations and reschedules. With three no shows, you may be terminated from the practice.

_____ (initial) Refill Policy

For any refills, first call your pharmacy; they will contact us. Routine refills will be called back to your pharmacy within two business days. Please remember that we are not here on the weekends or after 5:00 pm. This may seem like a long time, but it is necessary to provide you with the best medical care. Part of that care is ensuring that you have the appropriate lab work and follow-ups required for your condition. In order for this to occur, the provider must properly review your medical record before refilling medication. Make sure you allow plenty of time BEFORE you run out of medication to get your refill.

_____ (initial) Nurse Call Backs

Each medical assistant at the clinic has a voice mail. Usually you will be asked to leave any messages on that voice mail which is checked at the end of each day. The calls are returned by the next business day. If your concern is urgent and cannot wait until then, you may speak with the operator. If the nurse is not available, a message will be taken and it will be hand delivered. Our nurses are sometimes not available to speak directly to patients when they call because they are taking care of patients in the office. They do, however set aside time daily to return calls.

_____ (initial) Nurse Visits

Nurse visits are by appointment only, Monday through Friday from 8:30 am to 11:00 am and from 1:30 pm to 4:00 pm. Make sure that you find out if you need to be fasting for any labs ordered. These times are for labs or injections ordered by OUR providers. We DO NOT draw labs for other doctors.

_____ (initial) Saturday Urgent Care Clinic

We see patients for urgent care only on a first come first served walk-in basis on Saturday mornings. Although the phones are not answered on Saturday, the clinic is open from 8:00 am to 10:30 am. There is an additional $25.00 after hour fee, along with your copay on Saturdays. We do not provide routine medical care such as physicals, labs draws or blood pressure checks on Saturday without prior approval.

_____	_____	___/___/_____
Patient or Guarantor Signature	Patient Name	Date of Birth
_____	_____	___/___/_____
Guarantor Name	Relation to Patient	Date

Northwest Diagnostic

Acknowledgment of Review of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ ____/____/_____
Patient or Guarantor Signature Date

_____ ____/____/_____
Patient Name Date of Birth

_____ _____
Guarantor Name Relation to Patient

Please list all dependents that are under our care:

Name _____ Date of Birth ____/____/_____
Name _____ Date of Birth ____/____/_____
Name _____ Date of Birth ____/____/_____
Name _____ Date of Birth ____/____/_____
Name _____ Date of Birth ____/____/_____

Contact Person for Questions and Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Northwest Diagnostic Clinic
500 W. Whitestone Blvd., Ste. 100
Cedar Park, TX 78613
www.nwdclinic.com

Privacy Officer
Sue McBurney
(512) 250-3900
sue@nwdclinic.com

Northwest Diagnostic

HIPAA
Authorization to Release Medical Information to Individuals/Family Members

_____ ___/___/_____
Patient Name Date of Birth

In accordance with federal government privacy rules implemented through The Health Insurance Portability and Accountability Act of 1996 (HIPAA), in order for your physician or staff of Northwest Diagnostic Clinic to discuss your condition or finances with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived. I understand that I may revoke this authorization in writing at any time.

Please initial one of the following:

_____ **I do not** authorize Northwest Diagnostic Clinic to release any or all information concerning my medical care or finances to any individual except as set forth above.

_____ I authorize Northwest Diagnostic Clinic to release any or all information concerning my medical care or finances to the following individuals via written, electronic, or verbal communication:

First and Last Name:	Relation to patient:	Date of Birth:
_____	_____	___/___/_____
_____	_____	___/___/_____
_____	_____	___/___/_____
_____	_____	___/___/_____
_____	_____	___/___/_____

_____ ___/___/_____
Patient or Guarantor Signature Date

_____ _____
Guarantor Name Relation to Patient

**** I revoke all authorizations to the above named individual(s) effective immediately. ****

_____ ___/___/_____
Patient or Guarantor Signature Date