

Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**Please list ALL current medications, vitamins, herbs or non-food supplements**

Medication	Dose	Frequency	Medication	Dose	Frequency

**Any chronic or recurring conditions?**

**Any hospitalizations or major illnesses? Any surgeries (including wisdom teeth)?**

**Please list any specialists that you have seen in the past few years and why.**

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**Allergies or reactions to medications, or other agents**

Medication	Reaction or side effect	Medication	Reaction or side effect

**Tobacco use**

Never smoked     Current smoker     Former smoker, quit date: \_\_\_\_\_

Total history of use:    Average packs/day: \_\_\_ for #of years: \_\_\_.

Other tobacco:  pipe  cigar  snuff  chew     other

**Alcohol use**

Drinks in a typical week \_\_\_\_\_

Does your drinking worry you or others?  yes     no

**Drug use**

Have you ever used recreational drugs?     No     Yes: \_\_\_\_\_

Still using?     No     Yes: \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Average daily caffeine use**

# coffee: (6oz = 1 serving) \_\_\_\_\_ # tea \_\_\_\_\_ # cans of soda \_\_\_\_\_ # energy drinks \_\_\_\_\_

**Exercise:** Any regular exercise?  Yes  No. Type, hours per week: \_\_\_\_\_

**Current occupation:** \_\_\_\_\_ **Occupational hazards:** \_\_\_\_\_

**Average hours worked weekly including commute:** \_\_\_\_\_

Activities and hobbies: \_\_\_\_\_

**Education completed:**  grade  high  trade  college  masters  graduate

**Marital status:**  single  married  divorced  separated  widowed/er  co-habiting

**Sexually active**  Yes  No

Sex partners are  male  female

**Contraception and protection:** Birth control method: \_\_\_\_\_

Have you ever had any sexually transmitted diseases?  Yes  No

If yes, please explain: \_\_\_\_\_

**History of blood transfusion?**  Yes  No **Any tattoos?**  Yes  No

**Women's gynecologic history:**

# pregnancies: \_\_\_\_ # abortions: \_\_\_\_ # miscarriages: \_\_\_\_ # c-sections \_\_\_\_ # vaginal deliveries: \_\_\_\_

1<sup>st</sup> day, most recent period \_\_\_\_\_ Age at onset of periods: \_\_\_\_\_

Frequency of periods: \_\_\_\_\_ Length of periods: \_\_\_\_\_

Ever had an abnormal pap?  Yes  No

**Personal and Family history**

Please note major medical conditions of your family members.

Please be as specific as possible.

Mom: \_\_\_\_\_

Dad: \_\_\_\_\_

Children: \_\_\_\_\_

Other relatives: \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Review of Systems** (this is to check for past or recurring issues)

<b>Constitutional:</b>	Y	N	<b>Musculoskeletal:</b>	Y	N
Chronic poor sleep			Frequent joint or bone pain		
Chronic fatigue, excessive sleepiness			Unexplained muscle pain		
Chronic pain			Constant urge to move legs		
Unexplained weight loss or gain			Leg swelling		
<b>Neurologic:</b>	Y	N	<b>Skin:</b>	Y	N
Recurring dizziness			Recurring rash, itch		
Headaches more than 3 per month			Non-healing lesions, wounds		
Numbness or tingling			Unexplained lumps or bumps		
<b>Ever</b> had seizures			<b>Endocrine:</b>	Y	N
Significant memory loss			Recurring irregular periods or cramps		
<b>Eyes/ears/nose/mouth:</b>	Y	N	Excessive thirst, hunger		
Eye issues (other than glasses)			Often feel too hot or cold		
Recurring sinus infections			<b>Genitourinary:</b>	Y	N
Loss of hearing, ringing in ear			Difficulty starting stream		
Seasonal allergies			Frequent or small voids		
Difficulty swallowing			Urinate more than twice per night		
<b>Respiratory:</b>	Y	N	Leaking urine		
Recurring shortness of breath			<b>Hematologic/Immunologic:</b>	Y	N
Frequent cough or wheezing			History of non-pregnancy anemia		
Frequent or loud snoring			<b>Ever</b> had blood clot, clotting disorder		
Recurring lung infections			<b>Ever</b> had severe allergic reaction		
<b>Cardiovascular:</b>	Y	N	<b>Psychiatric:</b>	Y	N
<b>Ever</b> had bad chest pain			<b>Ever</b> had major depression		
High blood pressure			Anxiety, excessive worrying		
High cholesterol or lipids			Frequent mood swings		
<b>Gastrointestinal:</b>	Y	N	<b>Sexual:</b>	Y	N
Recurring abdominal pain			Sexually active		
Recurring nausea, upset stomach			Erectile or vaginal issues		
Indigestion/heartburn			Poor performance or low sex drive		
Irregular bowel movements (normal is 3-14/week without straining)			Breast or testicular lumps		
Difficulty swallowing; choking episodes			<b>Other:</b>		
			<b>Other:</b>		



# Trophy Club Family Medicine PA

945 TROPHY CLUB DR  
TROPHY CLUB TX 76262-5580  
Ph: 817-430-9111 Fax:817-430-8911

## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name:

Date:

Over the last 2 weeks, how often have you been bothered by any of the following problems?  
(Use "x" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1) Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) Feeling bad about yourself or that you are a failure, or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8) Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9) Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Score:

### Interpretation

- Minimal Depression
- Mild Depression
- Moderate Depression
- Moderately Severe Depression
- Severe Depression

### Interpretation of Total Score for Depression Severity

- 1-4 Minimal depression
- 5-9 Mild depression
- 10-14 Moderate depression
- 15-19 Moderately severe depression
- 20-27 Severe depression

Source: Adapted from materials prepared by: Kroenke K, Spitzer R, Williams W. The PHQ-9: Validity of a brief depression severity measure. JGIM, 2001, 16:606-616

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## TROPHY CLUB FAMILY MEDICINE

Today's date:			PCP:			
<b>PATIENT INFORMATION</b>						
Patient's Last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss	<input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Primary language		Ethnicity		Birth date:	Age:	Sex:
				/ /		<input type="checkbox"/> M <input type="checkbox"/> F
Mailing Address:			Social Security no.:		Best Phone # to Reach you at:	
					(   )	
Preferred Pharmacy		Pharmacy Address			Pharmacy Phone Number	
Chose clinic because/Referred to clinic by (please check one box):						
<input type="checkbox"/> Dr. <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to home/work <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other						
Other family members seen here:						
PLEASE PROVIDE EMAIL ADDRESS FOR OUR SECURE PATIENT PORTAL WEBSITE:						
<b>INSURANCE INFORMATION CLASS</b>						
(Please give your insurance card to the receptionist.)						
Person responsible for bill:		Birth date:	Address (if different):		Home phone no.:	
		/ /			(   )	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Occupation:	Employer:	Employer address:			Employer phone no.:	
					(   )	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Primary Insurance						
Secondary Insurance						
Subscriber's name:		Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	
			/ /			
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						
DO WE HAVE PERMISSION TO: Leave a message on your answering machine at home or your cell phone?   YES   NO Leave a message at your place of employment?   YES   NO Discuss your medical condition with any member of your household?   YES   NO  IF YES: Name <span style="float: right;">Relationship to Patient</span>						
<b>IN CASE OF EMERGENCY</b>						
Name of local friend or relative			Relationship to patient:	Home phone no.:	Work phone no.:	
				(   )	(   )	
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Trophy Club Family Medicine or insurance company to release any information required to process my claims.						
Patient/Guardian signature					Date	



## **Trophy Club Family Medicine**

945 Trophy Club Drive  
Trophy Club, TX 76262  
Phone: 817-430-9111 Fax: 817-430-8911

### **Welcome to your Medical Home**

A medical home is a team approach providing total healthcare. Your medical home will include your healthcare provider, others who support you, and yourself.

### **Why is it important to have a Medical Home team?**

Your medical home can:

1. Help you manage your healthcare by using evidence-based care and self-management support
2. Help answer your health questions
3. Listen to your concerns
4. Work with other medical experts if necessary
5. Coordinate your care through additional services
6. Encourage you to play an active part in your own healthcare

What can **YOU** do to help?

1. Be an active team player
  - a. Talk with your team about your health questions
  - b. Share your past healthcare successes and challenges
  - c. Tell your team about other healthcare professionals who care for you
  - d. Tell your team how you feel about the care you are getting from them
2. Take care of your health
  - a. Follow the healthcare plan you and your team have talked about. Make sure you understand how to follow the plan. Set goals you can reach. Once you begin to see results, you and your team can discuss adding new goals.
3. Talk openly with your team
  - a. Tell your team if you are having trouble sticking with your care plan
  - b. Speak up if your care plan is not working. Tell your team what is not working so together you can make changes if needed.

### **WE HAVE OUTLINED OUR OFFICE POLICIES THAT HELP US SERVE YOU BETTER.**

**Please read these carefully and completely and sign below**

#### **Clinic Hours**

**Monday – Friday: 8:00am to 12:00pm and 1:00pm to 5:00pm (Closed for lunch)**

#### **Appointments**

Appointments can be made during regular business hours. If you are unable to keep your appointment, **you must contact within 24 hours of your appointment** or there will be a **\$40 minimum**

**CANCELLATION/NO SHOW charge** depending on the type of appointment you had scheduled. If you arrive late for your appointment, we will make every attempt to see you. However, your appointment may have to be rescheduled.

#### **Telephone Calls/Web messages for the Providers, Medical Assistants, and for Scheduling**

Our phones are answered and web messages are checked throughout the day during our normal business hours. A medical assistant will return all calls/messages received before 4:00pm by the end of the day. Calls and messages received after 4:00pm will be returned by the end of the next business morning.

### **After Hours Emergency Calls**

Our providers are always available after hours, 5:00pm to 8:30am, for emergency calls. Night and weekend coverage is shared with all our providers. Call our main number 817-430-9111 and follow instructions to reach the provider on call. In a life-threatening situation, please call 911 or go to the nearest Emergency Room.

### **Prescriptions**

Your medical records are needed to determine whether a refill should be issued, therefore refills CANNOT be approved after normal business hours or weekends. During your visit your Provider will give you prescriptions in amounts to last until you need to be seen again. Follow up appointments are scheduled so that your Provider will can monitor your condition and adjust medications accordingly. To ensure appointment availability, please make this appointment at the time of your current visit or at the time you get your last refill. Prescription requests received after 4:00pm will be processed by the end of the next business day. We do not refill medications after hours or weekends. If you do find your self in need of more medication prior to your appointment, please call your pharmacy, who will call us for any additional refills. Please allow 24 to 72 hours to approve or deny any refill. ***Our office ha a NO SHOW, NO MEDICATION policy. Failure to show up for your appointment will result in a denial for medication.***

### **Referrals**

Some managed care plans require your primary care doctor to obtain authorization to be referred to a specialist. If your managed care plan requires this, we will obtain authorization from your insurance company ***within 7 to 14 business days***. Please do not make an appointment with the specialist until you have received a call from our referral department or until you have received a call from the specialist.

### **Outpatient Procedures**

We will obtain an authorization from your insurance company and you will be contacted by the facility to which you are being sent to within 5 business days to schedule your procedure. Your results will be discussed at your follow-up appointment.

### **Lab Results**

***Please sign up for our patient portal so you can receive your results quickly.***

- Acute illness lab results:
  - All lab results will be reviewed at a follow-up appointment, or a secure message will be sent to your portal.
- Chronic disease results:
  - Labs are drawn 1 week prior to your appointment if there is a standing order. Results will be reviewed at your follow-up appointment.
- Surgical biopsy results:
  - You will either be sent a secure message within 10 to 14 days or the result will be reviewed during your suture removal appointment.

### **Treatment of a Minor**

A minor is under the age of 18 who has never been married and who has never been declared an adult by a court. Generally, minors do not have the legal capacity to consent to medical treatment.

- Minors aged 17 and under **MUST** be accompanied by a parent or legal guardian.

### **Immunizations**

Please be aware that we need an updated immunization record for all patients. We will be happy to copy it and return the original to you.

### **Managed Care**

We accept dozens of insurance plans, including Medicare and Medigap carriers with various deductibles, co-pays and coverages. We cannot know all of the limitations and rules of your insurance plan. It is important that you read, know and understand the provisions of your insurance policy. Please bring your insurance card along with a picture ID to every visit.

**Responsibility for Ensuring Insurance Coverage**

You are responsible for ensuring that we are the providers on your insurance plan and for knowing what services you have coverage for, including but not limited to:

- Annual deductible
- Co-payments
- X-rays
- Weight control
- Psychological services
- Cosmetic services
- Procedures

You will be responsible for paying all services not covered by your insurance plan. We will bill both your primary and secondary insurance plans, as long as we are contracted. You may be asked to sign a Waiver of Liability form in the event that a service is provided in which we know is not covered by your plan. If you have Medicare as well as a secondary plan that is not Medigap, we will file a claim to your supplemental carrier. In the event that we are unaware if a charge is covered or not by your insurance plan, your balance will be billed to you after we obtain a denial from your insurance carrier.

**Private Pay Patients**

Payment is due at the time of services. If you are unable to pay for services in full, you must arrange a payment plan prior to your appointment with our billing department.

**ALL PAYMENTS ARE DUE AT CHECK OUT**

**Motor Vehicle Accidents (MVA)**

We **DO NOT** file charges to MVA insurance policies. All charges for services rendered due to a MVA will be filed with your insurance company. Any remaining balance not covered will be due in full at the time of your visit. You will need to submit your charges and seek reimbursement from the MVA insurance company.

**Third Party Liability**

“Third Party Liability” means that someone else’s insurance is to cover your illness/injury. For example, a fall at a grocery store, where the grocery store’s insurance will pay for your medical bills. We do not file charges for payment to attorneys or any other third-party payer. All charges for services rendered are payable in full at the time of your visit. You will need to submit your charges and seek reimbursement from the third-party insurance payer.

**Workman’s Compensation**

We do not file workman’s compensation insurance; therefore we cannot treat any work related illness or injury. Due to Texas State Laws, you could be denied benefits if you claim your condition is not work related but actually is work related.

**Letters and Forms**

There will be a \$25 charge for any letter the physician has to initiate, if not in conjunction with an office visit. Any forms such as insurance application, disability, adoption, employer forms, or family medical leave will also cost \$25.

**Your signature signifies that you have read and understand the above pages and understand your responsibility regarding charges incurred in this office.**

\_\_\_\_\_  
Patient Signature (or Guardian, if minor)

\_\_\_\_\_  
Date

# TROPHY CLUB FAMILY MEDICINE

## Patient Consent for the Disclosure of Information

I have read the **NOTICE OF PRIVACY PRACTICES** and have had any questions answered by this office. I understand that by signing this form I consent to the following:

- a) Sharing of Information for Purposes of Treatment: You will share my information with all members of my treatment team, both within this office and with other providers (personal and institutional) in order to provide me with the quality care and the educational/wellness programs specified by my insurance plan.
  
- b) Sharing of Information for Purposes of Payment: You will share all necessary information with my insurer(s), payer(s), governmental entities (such as Medicare, Tricare, etc.) and their representatives [including, but not limited to benefit determination and utilization review] as well as your representatives involved in the billing process [including, but not limited to claims representatives, data warehouses, and billing companies].
  
- c) Sharing of Information for Purposes of Operations: You will share all information necessary for ongoing operations in this office, including but not limited to the credentialing processes, peer review, accreditation and compliance with all federal and state laws.

**My consent is freely given, I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.**

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Patient Name (Please Print)

Date

---

Patient Signature (or Guardian, if minor)

Date

---

Witness (Optional)

Date

## TROPHY CLUB FAMILY MEDICINE

### Welcome to Trophy Club Family Medicine!

Date: \_\_\_\_\_

**Please let us know how you heard about our Practice. What made you pick up the phone and call us to make an appointment? Select all that apply.**

\_\_\_\_\_ Word of mouth: Friend Neighbor Co-Worker Family Other: \_\_\_\_\_

\_\_\_\_\_ Drove by building

\_\_\_\_\_ Saw sign/advertisement

\_\_\_\_\_ Insurance Website

\_\_\_\_\_ Website: What search engine did you use? Google Yahoo Microsoft Edge Bing Other: \_\_\_\_\_

What did you search for? \_\_\_\_\_

### **Why did you change from your current Doctor / Clinic?**

\_\_\_\_\_ New to the area

\_\_\_\_\_ Do not have a current Doctor / Clinic

\_\_\_\_\_ Insurance change: Current doctor is no longer on your plan, got a new plan, etc.

\_\_\_\_\_ Unhappy with last Doctor / Clinic

Why? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Other: \_\_\_\_\_