

Cypress Physicians Associations

Adult Medical Questionnaire

Patient Name: _____ Date of Birth: _____
 Previous Physician: _____ Today's Date: _____

Reason for today's visit	Date problem began (if applicable)

Past Medical History: Please mark if you or your family members have had any of the following:						
	Self	Father	Mother	Sibling	Child	Others
High blood pressure						
Heart blockage/attack/stent						
Heart disease						
Arrhythmia						
High cholesterol						
Diabetes						
Thyroid problems						
Cancer (type)						
COPD/emphysema						
Asthma						
Sleep Apnea						
Stomach Ulcers						
Seizures						
Migraines						
Depression						
Anxiety						
Other psychiatric illness						
Alcoholism						
Kidney problems						
Stroke or TIA						
Allergies/hay fever						
Arthritis						
Osteoporosis/fracture						
Other:						

Surgical History: Please mark if you have had any of these surgeries (what YEAR)	
Heart bypass	
Angioplasty/stents	
Pacemaker	
Appendix removal	
Gallbladder removal	
Tonsil removal	
Hernia repair	
Back surgery	
Joint surgery (type)	
C-section	
Tubal ligation	
Hysterectomy	
Vasectomy	
Breast augmentation	
Mastectomy	
Breast lump removal	
Cataracts	
Other:	

MEDICATIONS: Please list all prescription, over-the-counter, or herbal supplements you are taking				
Medication	Dosage	Frequency	Purpose/Use	Need refill today?
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No

Allergies to Medication/Food/Other: PLEASE DESCRIBE THE REACTION (rash, nausea, etc)

--

Review of Systems: Are you CURRENTLY having any of the following symptoms?				
Fever		Cough		Arm/leg weakness
Chills		Wheezing		Joint pain
Weight Loss		Short of breath		Muscle pain
Weight Gain				Leg Pain
Fatigue		Nausea/Vomiting		Back pain
Swollen Glands		Diarrhea		Numbness/tingling
		Constipation		Difficulty walking
Double vision		Abdominal pain		
Blurred/Poor Vision		Difficulty swallowing		Fainting spells
Eye pain		Heartburn		Headaches
ringing in ears		Bloody/black stools		Dizziness
Ear pain		Hemorrhoids		Seizures
Nose bleeds		Loss of appetite		
Decreased hearing				Depression/anxiety
Sinus pain/drainage		Urinate at night		Sleeping difficulty
Sore throat		Urgency to urinate		Memory problems
		Blood in urine		Suicidal thoughts
Chest Pain		Incontinence		Concentration difficulty
Palpitations		Pain/burn with urinating		
Irregular pulse				Infertility
Leg swelling		Rashes/Hives		Vaginal discharge
Varicose veins		Nail fungus		Breast pain
Snoring		Changing mole		Erectile dysfunction

Alcohol (amount/type/frequency)	Coffee/Tea/Caffeine (cups/day)	Smoking Current Packs/day	Past/Quit # of years	No
Year of last vaccine	Flu	Tetanus/TD	Pneumonia	Shingles
Concerns about safety or abuse at home? Yes / No			Occupation:	
Married	Single	Widowed	Divorced	# of children:

Year of last test (Please circle if test was abnormal)	Prostate (males)	Colonoscopy	Cardiac stress test
	TB Test	Eye exam	Dental exam
	Bone Density	Mammogram	Pap smear (female)

Females				
Menstrual flow: Regular Irregular Heavy	Days of flow:	Days between menses:		
1 st day of last cycle:	Number of pregnancies:	Number of live births:	Number of abortions:	Number of Miscarriages:
Pain after sex: Yes No	Birth control: Yes No	Type of birth control:	Name of Birth control:	

List any other physicians that you see/ Specialty	

Cypress Physicians Association

Patient Information

Date: _____

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Marital Status: Married Divorced Widowed Single Gender: Male Female

Social Security Number: _____ Driver's License Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Patient Cell Phone: _____ Spouse Cell Phone: _____

Other: _____ E-Mail Address: _____

Please give us as many phone numbers as possible in case we need to reach you regarding lab/test results.

Patient Employed by: _____

Work Phone: _____ Position: _____

Pharmacy Names and Numbers:

Local _____ Mail Order _____

Insurance Policy Holder's Information (Patient's spouse or responsible party)

Insurance Company Name: _____

Patient relationship to insurance policy holder: Self Spouse Child Other _____

Insured's Last Name: _____ First Name: _____ MI: _____

Insured's DOB: _____ Insured's Social Security Number: _____

Insured's Home Phone: _____ Cell Phone: _____ E-Mail _____

Employer Information: Company Name: _____ Phone: _____

In case of emergency, please list a family member and a non-relative person in which we may contact.

Family Member: _____ Home Phone: _____ Cell Phone: _____

Non-relative Person: _____ Home Phone: _____ Cell Phone: _____

Name of Spouse: _____ Date of Birth: _____ Phone No: _____

Cypress Physicians Association

Ethnicity and race are a major factor affecting the health of individuals and communities. New health guidelines are requiring us to document your ethnicity and race. Please choose a race and an ethnicity from the list below:

Race:

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic
- Native Hawaiian or Other Pacific Island
- White
- Other Race
- Declined**

Ethnicity:

- Not Hispanic or Latino
- Hispanic or Latino
- Other
- Declined**

Preferred Language: _____

Print Patient Name: _____

Date of Birth: _____

Signature: _____

Date: _____

No Show Policy

Appointments are in high demand, and your early cancellation will give another patient the chance to have access to timely medical care.

This policy does not apply to patients who call to patients who have sudden emergencies **less than 24 hours** before their appointment.

For missed appointments, a “**No Show Fee**” charge of **\$20** will be charged to the patient after the second "No Show". This charge is **NOT** billable to the insurance company and, therefore, will be due before future services are rendered. After 3 (three) "No Show" in 12 months from the 1st "No Show", the patient may be dismissed from the practice.

initials

Preclinical Laboratory/Imaging and health optimization policy

In order to provide you the best possible medical care for chronic and routine medical conditions, you **MUST** have your **LABS** drawn and **RADIOLOGY** imaging performed 1 week prior to your office visit. Our practice policy is that lab or imaging results will be only be discussed during an office visit. This allows you to ask questions and address any concerns that you may have regarding your care. It also allows us to appropriately adjust your medications and/or other treatments and work towards achieving your optimal health. If you **DO NOT** have your labs drawn **AHEAD** of time, you may be asked to **RESCHEDULE** your appointment.

Additionally, it is encouraged that you bring your following to your appointment:

- You're actual medication bottles (or at least a list of your current medications and doses) to ensure that the accuracy of our documentation and to verify medications from other medical providers.
- For high blood pressure
- A logbook of your blood pressure readings and your bp machine.
- For diabetes
- A logbook of your blood sugar readings and a log of your insulin dosing (if applicable)

initials

Preventive Care Exam information

Your preventive care exam (aka "annual physical exam", well women and well child) is a specific service designed to screen for and prevent health issues. It may include a clinical examination, laboratory tests, procedures, counseling, and/or immunizations depending on your age, gender and other risk factors.

In most cases, the preventive care exam is free to you. The Affordable Care Act obligates most insurance plans to pay for this service without charging you a co-payment, co-insurance, or deductible.

However, there are important exceptions to this rule: the evaluation and management of new or existing health issues is **NOT covered** under the preventive care exam. Thus, the evaluation and management of new or existing health issues during the preventive care exam will generate charges that will be your responsibility (including but not limited to co-payment, co-insurance and deductible.) Please note that a medication refill falls responsible for any additional charges incurred if new or existing health issues are evaluated and managed during the preventive care exam.

initials

Consent for Treatment

Cypress Physicians Association has on staff Physicians Assistants and advanced Nurse Practitioners to assist in the delivery of medical care.

A physician assistant is a graduate of an accredited Physician Assistant program, certified by the NCCPA Board and licensed by the Texas Medical Board. An advanced nurse practitioner is a graduate of an accredited Advanced Practice Nursing program, licensed by the Texas Nursing Board. Under the supervision of a physicians, a physician assistant can diagnose, treat and monitor acute and chronic diseases as well as provide health maintenance care. Supervision does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided. A physician assistant may provide such medical services that are within his/her education, training and experience. These services may include: obtaining histories and performing physical exams; ordering and/or performing diagnostic and therapeutic procedures; formulating a working diagnosis; developing and implementing a treatment plan; monitoring the effectiveness of therapeutic interventions; assisting at surgery; supplying sample medications and writing prescriptions; making appropriate referrals.

My initial below signifies that I have read the above and hereby consent to the services of a physician assistant or advanced nurse practitioner for my health care needs. I understand that I can refuse to see a physician assistant or advanced nurse practitioner and request to see a physicians. I understand that this refusal may cause a delay in the time of my appointment.

_____ **initials**

Acknowledgement Notice of Privacy Practices

My signature below signifies that **Cypress Physicians Association's** Notice of Privacy Practices describes the types of uses and disclosures of protected health information (PHI) that will occur in patient treatment, payment of bills or in the performance of health care operations of **Cypress Physicians Association**. The Notice of Privacy Practices of **Cypress Physicians Association** is also provided at the front desk. This Notice of Practices also describes patient rights and **Cypress Physicians Association's** duties with respect to protect patient health information.

Name: _____

Signature: _____

Date: _____

Confidential Communication Request

Cell phone number: _____
Work phone number: _____
Home phone number: _____
E-Mail address: _____

Cypress Physician's Association will only release or discuss your health information with your written consent.

If you **DO NOT** want your information released to **ANYONE** else, please sign below:

(Signature) _____ (Date)

If you would **LIKE** to have anyone else be able or discuss/receive your health information, please list their names below and sign:

(Name of authorized person/relationship) _____ (Contact info - phone/email)

(Name of authorized person/relationship) _____ (Contact info - phone/email)

(Name of authorized person/relationship) _____ (Contact info - phone/email)

(Patient/guardian signature) _____ (Date)

Cypress Physicians Association

Assignment and Release

I, the undersigned, have coverage with _____ and assign directly to Cypress Physicians Assoc. all medical benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature for all insurance submissions.

I further authorize the use of this signature as Treatment Authorization and give permission to Cypress Physicians Assoc. to give me reasonable and proper medical care based on today's standards.

I further authorize the use of this signature as Lab and Insurance Submission Consent and give permission to Cypress Physicians Assoc. to submit blood specimens to the lab of choice for analysis and study. I also authorize the submission for payment to my insurance for charges incurred for said labs and further agree to full responsibility for payment of any non-covered services.

Medicare Participants: I request that payment of the authorized Medicare benefits be made on my behalf to Cypress Physicians Assoc. for any services rendered by the physicians of this group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of the benefits payable for related service. I understand that my signature request that payment be indicated in item 9 of the HCFA-1500 form, or elsewhere on other claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. The Physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

As responsible party for this account I agree to pay the balance due. Should the billing department need to contact me in regards to this account and are unable to reach me by mail or home phone, then I may be reached at the work place.

Patient name (printed): _____

DOB: _____

Signature: _____

Date: _____

(Patient or person authorized to give consent)