PETERSON
MEDICAL ASSOCIATES

Location 1: 575 Hill Country Drive, Suite 101
Location 2: 1331 Bandera Hwy. Suite 3
Kerrville, Texas 78028
Phone: (830) 258-7762 Fax: (830) 258-7198

Dear New Patient,

We have enclosed your new patient paperwork with this letter. Please complete the forms in their entirety. The paperwork may be returned in person, by mail or fax to # (830) 258-7198.

On the day of your appointment, please bring with you:

- Your insurance cards and photo identification (preferably driver's license).
- Any prescription medicines you are taking (in the original packaging).
- If you use a mail-in prescription service, bring your drug formulary list that shows which medicines they pay for.
- Any over-the-counter supplements.
- Please arrive 15 minutes early for check in process.

Thank you for choosing Peterson Medical Associates as your healthcare provider. We look forward to meeting you. If you have any questions, please let us know at 830-258-7762.

Sincerely,

Peterson Medical Associates Staff

Peterson Medical Associates

PATIENT INFORMATION SHEET

Patient Name (last, first, MI):	**Gender:** M F	**Date of Birth (MM/DD/YY):**	**Social Security Number:**
Mailing Address:		**Home Phone (Primary Y/N):**	**Work Phone:**
City: **State:** **Zip:**		**Cell Ph #/Pager (Primary Y/N):**	**Marital Status:**
Ethnicity/Race:		**Maiden Name:**	**Driver's License #:**
Preferred Local Pharmacy: **Preferred Mail-In Pharmacy:**		**How did you hear about us?**	
Employment Status: (Circle One) Employed Full-Time Student Part-Time Student Retired		**Occupation:**	
Patient's Employer:		**Employer's Address:**	
Emergency Contact with Phone and Relationship to Contact:		**Patient Email Address:**	
Spouse's Name:		**Spouse's SSN:**	**Spouses DOB:**
Spouse's Employer & Telephone Number:		**Other Household Members:**	
Responsible Party (Fill out only if other than patient.)			
Name:		**Relationship to Patient:**	
Address:		**Employer & Telephone Number:**	
Home Phone:	**Cell Phone:**	**Social Security Number:**	**Date of Birth:**
Health Insurance Information			
Primary Insurance Health Care Plan:		**Secondary Insurance Health Care Plan:**	
ID#	**Group #**	**ID#**	**Group #**
Name of Policy Holder (last, first, MI):		**Name of Policy Holder (last, first, MI):**	
Policy Holder's Address:		**Policy Holder's Address:**	
Telephone Number:	**Date of Birth:**	**Telephone Number:**	**Date of Birth:**
Social Security Number:	**Relationship to Patient:**	**Social Security Number:**	**Relationship to Patient:**

AFTER CLINIC HOURS (4:45 PM TO 8:00 AM) AND WEEKENDS: You may reach the ON-CALL PMA Physician by calling our office at 830-258-7762 and following the instructions as given.

All services rendered are the financial responsibility of the patient or the patient's parent or guardian. The patient is responsible for payment regardless of insurance coverage. Billing information will be provided to expedite patient reimbursement from private insurance carriers.

I hereby authorize the provider of services to release information concerning my examination and/or treatment for insurance purposes and to receive direct payment for benefits payable to me for services rendered. I also authorize release of medical information for the purpose of further evaluation or treatment.

Signature _____ Date _____

Peterson Medical Associates

PRACTICE POLICIES AND GUIDELINES AGREEMENT

Welcome! We are so glad that you have decided to become a part of our practice. Our goal is to provide you with excellent healthcare in a friendly and compassionate environment. Please take a moment to become familiar with our office's policies and guidelines, then sign the acknowledgement at the bottom of this page and return it to our office. Thank you for your cooperation.

First Time Visit: Please arrive at least 15 minutes prior to your appointment time. A nurse will go over your past medical history. Please bring all of your medications in their original containers. If you have a co-pay or have not yet met your deductible, please be prepared to pay it when you check in at the front desk. If you are a self-pay patient, payment will be due at the time of service.

Follow-Up Visits: Please arrive 5 – 10 minutes before your schedule appointment time. It is our goal for you to be ready to see your physician on time. Follow-ups are scheduled based on the particular needs of specific disease processes. If you have multiple chronic illnesses, you may be scheduled for multiple follow-up visits.

Late Arrivals: We all run late sometimes. In the event that you are late for your appointment, we will try our best to work you back in to the schedule. Depending on how busy we are, you may be required to reschedule your appointment.

Appointment Cancellations: We understand that sometimes plans change. We ask that you reschedule appointments *at least* 24 hours in advance so that we may give that time to someone else. Although unexpected events may necessitate missing an appointment, if you miss 2 appointments without following the cancellation protocol then you will be charged $25.00. If you miss 3 appointments without following the cancellation protocol, you may be dismissed from the practice. You will receive a written warning notification if you miss 2 appointments.

Sick Visits: Established patients who need acute care should call as early in the day as possible so that we can accommodate you. Patients are seen by appointment only. Depending on the availability of your physician, you may be asked to see another provider.

Medication Refills: For non-emergency, and routine medication refills, please allow 48 hours and ask your pharmacy to send us a refill request. For any narcotic medications (ex. Norco, ADD meds) please allow 5 days notice. Also, please let a nurse or physician know if you need a 90 day prescription. Narcotic medications will only be written for a 30 day supply at a time. Additional refills to the original prescription will be at the doctor's discretion. Early refills will not be given. You may be requested to contact your pharmacy to ask them to fax a refill request to our office to assure that exact fill dates are documented accurately. You may also be asked for a follow-up appointment for certain refill requests.

AFTER CLINIC HOURS (4:45 PM TO 8:00 AM) AND WEEKENDS: You may reach the ON-CALL PMA Physician by calling our office at **830-258-7762** and following the instructions as given.

Please remember that your appointment is to focus on your medical needs. *If your family member, who is also our patient, has any medical needs (including medication refills), we will be happy to schedule an appointment for them at the conclusion of your office visit.*

As a courtesy, please turn off or silence your cell phone during your office visit.

I have read and understand the above office policies and agree to abide by them.

_____ _____

Signature Date

PETERSON
MEDICAL ASSOCIATES

Name_____ Today's date:_____

Date of Birth_____

What is the reason for your visit?

_____

Past Medical History – Have you ever had? (Circle **Yes or No**)

High Blood Pressure	**Yes**	**No**	Liver Disease	**Yes**	**No**
Heart Attack	**Yes**	**No**	Kidney Disease	**Yes**	**No**
Diabetes	**Yes**	**No**	Cancer	**Yes**	**No**
Stroke	**Yes**	**No**	Arthritis	**Yes**	**No**
Asthma	**Yes**	**No**	Stomach Ulcers	**Yes**	**No**
High Cholesterol	**Yes**	**No**	Thyroid(Hyper/Hypo)	**Yes**	**No**
COPD	**Yes**	**No**			

Other Medical Problems:

_____

_____

Past Surgical History – Have you ever had Surgery for? (Circle **Yes or No**)

Heart	**Yes**	**No**	Back or Spine	**Yes**	**No**
Gall Bladder	**Yes**	**No**	Tonsils	**Yes**	**No**
Appendix	**Yes**	**No**	Hysterectomy	**Yes**	**No**

Other Surgeries:

_____

Past Social History (Circle **Yes or No**)

Tobacco Use	**Yes**	**No**	Alcohol Use	**Yes**	**No**
Per day_____			never/moderate/freq_____		

_____ _____

Other Physicians Preferred Pharmacy

575 Hill Country Drive, Suite 101 • Kerrville, Texas 78028 • (830) 258-7762 • Fax (830) 258-7198

PETERSON
MEDICAL ASSOCIATES

Name_____ Today's Date_____

Date of Birth_____

Any Allergies to Medicine:_____

_____

Patient Medication List

Current Medications	Dose (ie mg or mcg)	How taken? (mouth or injection)	How many times taken daily?

Peterson Medical Associates
575 Hill Country Drive Ste 101 · Kerrville, TX 78028
Phone: (830) 258-7762 · **Fax:** (830) 258-7198

Authorization for Release of Medical Information

Name: _____
Date of Birth: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____

I hereby authorize (please list physician name and/or facility):

Dr. Name/Facility Name: _____
Address: _____
City: _____
State: _____ **Zip:** _____
Phone#: _____ **Fax #:** _____

to disclose information from my medical records to Peterson Medical Associates for the purpose of primary care. The specific information I wish to have released:

PLEASE SEND *ONLY* THE MOST RECENT OF THE FOLLOWING

Colonoscopies	Dexa Scans / Bone Density
Labs	Mammograms
PE / Wellness	Pap
Progress Note	Stress Tests
Xrays / Scans	Immunization Record
Living Wills, POA	Other: _____

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a one hundred eighty (180) day period from the date it is signed.

_____ _____
Signature Date

Expires: _____
Witness: _____

This medical record may contain information about drug abuse, alcohol abuse, venereal disease, abortion, or mental health treatment. Separate consent must be given before this information can be released.
□ DO consent / □ DO NOT consent to have this information disclosed.

_____ _____
Signature Date

This medical record may contain information concerning HIV testing and /or AIDS diagnosis treatment. Separate consent must be given before this information can be released.
□ DO consent / □ DO NOT consent to have this information disclosed.

_____ _____
Signature Date