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

575 Hill Country Drive, Ste 101 / 1331 Bandera Hwy, Ste 3
Kerrville, TX 78028
(830) 258-7762

PATIENT AUTHORIZATION FOR CONTACT & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

THIS FORM INSTRUCTS US WHO ELSE SHOULD GET YOUR MEDICAL INFORMATION. YOUR DOCTORS ARE ALWAYS INFORMED, SO DO NOT LIST THEM.

1. I authorize Peterson Medical Associates to disclose my protected health information to:

_____ Family member(s) (List): _____ Ph #: _____

_____ Ph #: _____

_____ Non-family member(s) (List): _____ Ph #: _____

_____ Myself only

2. I authorize the practice to disclose only the following protected health information to the individual(s) listed above:

   _____ Test results, reports, and general health updates

   _____ Nothing beyond general health questions & updates

3. I may be contacted with medical information by:

   e-mail: _____

   _____ Please send a detailed message to my email address.

   _____ Please send a message that only includes a call-back number and name at the doctor's office.

   Home: _____ **Cell:** _____

   _____ Please leave a detailed message on my answering machine/voice mail.

   _____ Please leave information with any of the individuals listed above.

   _____ Please leave a message with only call-back information with either an individual or on my answering machine / voice mail. Call back information will include doctor's name and staff member's name.

Expiration or termination of authorization – This authorization will remain in effect until terminated by patient's personal representative, or another individual of legal entity authorized to do so by court order or law.

Right to revoke or terminate – As stated in our Notice of Privacy practices, you have the right to revoke or terminate authorization by submitting a written request to our Privacy Manager.

_____ _____

Patient 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

PATIENT CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I understand that as a part of the provision of healthcare services, Peterson Medical Associates creates and maintains health records and other information describing among other things, my health history, symptoms, examination, and test results, diagnosis's, treatment, and any plans for future care or treatment.

The Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information is posted on the first floor at 575 Hill Country Drive in the foyer. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their privacy practices and the terms of this notice at any time. Upon your request, we will provide you with any revised Notice of Privacy Practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations (quality assessment and services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and healthcare operations. I have the right to revoke this consent in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.

2. A photocopy or fax of this consent is as valid as the original.

3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or healthcare operations, be restricted. I also understand that the Practice and I must agree to any restrictions in writing that I request on the use and disclosure of my Protected Health Information which have been previously agreed upon.

_____ _____

PATIENT OR PERSONAL REPRESENTATIVE OR GUARDIAN'S NAME PRINTED

DATE

_____ _____

PATIENT OR PERSONAL REPRESENTATIVE OR GUARDIAN SIGNATURE

SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)

_____ _____

WITNESS

DATE

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?

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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

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New Patient Medical History

Name: _____ Date of Birth: ___/___/____ Age: ____ Sex: ____
How did you hear about our practice?

♦ Please briefly state in the box below the reason for your visit ♦

♦ Past Medical History ♦

Condition / Disease	*Year Began*	*Condition / Disease*	*Year Began*
❑ Hypertension		Other(s):	
❑ High Cholesterol			
❑ Hypothyroidism (low thyroid)			
❑ COPD, Emphysema or Asthma			
❑ Diabetes			
❑ GERD			
❑ Depression or Anxiety			
❑ Heart Problems -			

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦

Operation / Hospitalization / Injury	*Month / Yr*	*Operation / Hospitalization / Injury*	*Month / Yr*

♦ Other Physicians and Specialists ♦

List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)

♦ Social, Educational and Work History ♦

Marital Status:	Age of children, if any:	
Work Status (circle one): Employed Unemployed / Retired / Disabled	Current or Prior Occupation:	Hours worked per week:
Highest Level of Education:	Completed at which institution / school:	
What type of exercises do you perform, duration & frequency?		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
What are your hobbies?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?		
Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		

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♦ Family Health History ♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	*Living or Deceased*	*Current age or age at death*	*Cause of Death*	*Health Problems*
Father:				
Mother:				
Brother(s):				
Sister(s):				

♦ Review of Systems ♦

Please review the following symptoms and circle those items that are a problem for you

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

☐ ***Place an "X" in the box to the left if you have none of the above.***

♦ Disease Prevention and Health Maintenance ♦

Please list below the most recent dates of your vaccines and health screening tests

	Month/Yr		*Month/Yr*		*Month/Yr*
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Ab Aneurysm Screen	
Gardasil Vaccine		Chest X-Ray		HIV Test	

Name:_____ Date of Birth _____

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 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