Methodist MEDICAL GROUP

PATIENT INFORMATION

Name		Date of Birth	Sex
Address	City	State	Zip
Phone Home	Work	Cell	
Email Address		Social Security Number	
Employer Name/Address	○ Full Time ○ Part Time	Student Status ○ Full Time – Student	○ NOT a Student ○ Part Time – Student
Race ○ Black/African American ○ Asian ○ Caucasian ○ Hispanic or Latino ○ Other (*Please Specify)*			
Ethnicity: ○ Hispanic or Latino ○ Not Hispanic ○ Decline to Provide		Marital Status ○ Single ○ Married ○ Divorced ○ Widow	
Primary Language Spoken in the Home ○ English ○ Spanish ○ Other (please define):			Veteran ○ Yes ○ No
Emergency Contact Name	Relationship	Phone	
Preferred Pharmacy: (Name, Address & Phone)			

RESPONSIBLE PARTY/GUARANTOR INFORMATION IF DIFFERENT FROM ABOVE

Name	Date of Birth	Relationship to Patient	
Address	City	State	Zip
Phone Home/Cell	Work	Social Security #:	

PRIMARY INSURANCE

Insurance Company Name		Phone Number	
Policy Number/Member ID Number	Group Number		
Address	City	State	Zip
Name of Insured Date of Birth	Relationship to Patient ○ Self ○ Spouse ○ Parent ○ Other		

SECONDARY INFURANCE IF APPLICABLE

Insurance Company Name		Phone Number	
Policy Number/Member ID Number	Group Number		
Address	City	State	Zip
Name of Insured Date of Birth	Relationship to Patient ○ Self ○ Spouse ○ Parent ○ Other		

Primary Care Provider (PCP)

Name	Phone Number	Fax Number
Address		

Referring Provider (if different from PCP)

Name	Phone Number	Fax Number
Address		

I certify that I have carefully reviewed this document, understand and have filled out truthfully.

Signature of Patient or Guardian (Relationship to Patient, If not signed by the Patient) Date

Patient Preference Regarding Communication of Health Information

In order to better protect your privacy under HIPAA, we have created this consent form for releasing medical information to family members and other people of your choosing. This will also be used for consent to leave you detailed telephone messages at the phone numbers listed below, mail your lab results to your home and also send secure email results to your personal email address once enrolled in MyChart. We are legally not allowed to release medical information to patient family members without the patient's written consent. The purpose of this document is to protect your privacy.

Communication to Family Members, Spouses or Other:
I authorize MMG and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below. I understand that by leaving spaces blank I am indicating my choice to be a "No Information" and I do not want any information released to anyone else.

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Emergency Contact Only: Name: _____ Relation: _____ Phone: _____

Communication for Appointment Reminders and Appointment Follow-Ups:
Methodist Medical Group (MMG) may need to use your name, phone number, email address ("Contact Information"), and your clinical records to contact you with appointment reminders and information about treatment alternatives, If this communication is made by phone and you are not available, a message will be left on your voice mail or with the person answering the phone. By signing this form, you are consenting for MMG to contact you with appointment reminders and information and to leave messages on a voice mail or with individuals at you home. Information that we use or disclosed based on this consent may be subject to re-disclosure by anyone who has access to the reminder and my no longer be protected by federal privacy rules.

You have the right to refuse to give MMG your consent to use your telephone number and/or email address for appointment reminders and treatment alternatives. If you chose to give your consent, you have the right to revoke it, in writing, at any time in the future. If you refuse to give MMG this consent or revoke it in the future, it will not affect the treatment we provide to you.

I CONSENT to the following forms of communication for appointment reminders and follow-up communication (*please initial all that apply*): ____ email ____ address ____ phone number ____ text message[1] ____ secure patient portal to be used in the manner described above.
Preferred Email Address _____ Preferred Telephone Number _____

If you consented to communication via the secure patient portal, you will be notified via email when there is secure information for you to review such as lab results. The email will provide a link that you will use to access the secure website. After clicking on the link, you will be required to log-in and provide your unique user name and password.

In choosing your email address, please consider privacy implications; for example, any other person that may have access to your email or any other person, such as your employer, that may have the right and/ or ability to review all email received at your work address.

____ (*initial*) I decline to give MMG consent to use my Contact Information and clinical records to contact me with appointment reminders and information about treatment alternatives. I understand I may be required to schedule a follow up appointment with the doctor for review my test results or it could take up to 10 business days to receive your results in the mail.

Consent and Agreement I have carefully reviewed this document and agree to fully comply with the guidelines defined herein for the communication of my health information.

_____ _____
Patient (Print Name) Date of Birth

_____ _____
Signature of Patient or Guardian Date

[1] Please note the text messaging service is a complimentary service provided by MTP, but standard messaging rates from your wireless carrier may still apply. If you have questions, please contact your wireless carrier.

General Patient Consent for Care

General Consent to Care:

I, _____, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided through Methodist Medical Group on an outpatient/ office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary.

I agree and acknowledge that Methodist Medical Group is not liable for the actions or omissions of, or the instructions given by the physicians/providers who treat me while I am a patient. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at Methodist Medical Group facilities.

Telemedicine

I understand that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. All electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPPA) and applicable state privacy laws.

To the Patient:

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

Signed Consent

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

This consent to medical treatment will expire 12 months from the date signed, or until revoked in writing.

_____ _____

Patient Name or Legal Guardian Date

_____ _____

Signature of Patient or Legal Guardian Relationship to Patient

Methodist MEDICAL GROUP

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PLEASE SEND RECORDS TO:

Trinity Surgical Consultants
2805 E President George Bush Hwy
Richardson, TX 75082
Ph (469) 204-5620
Fax (214) 947-8315

Name of Patient: _____ Date of Birth: _____ Age: _____ Sex: _____

Address: _____ City: _____ State: _____

Zip: _____ Home Phone: _____ Work Phone: _____

Social Security #: _____ Account Number: _____ Date of Last Visit: _____

Physician Seen: _____

1. I authorize the use or disclosure of the Patient's health information, as described below.
2. The following individual(s) or organizations are authorized to make the disclosure:

   Name: _____

   Address: _____

   Phone: _____ Fax: _____
3. The type and amount of information to be used or disclosed is as follows: (Please Check)
   ☐ Entire Health Record ☐ Operative Procedures ☐ Pathology Report ☐ Echocardiogram
   ☐ History & Physical ☐ X-ray/Imaging Reports ☐ X-ray Film ☐ Laboratory Reports
   ☐ Other (please describe)
4. I understand that the information in the Patient's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services, and treatment for alcohol and/or drug abuse.
5. This information may be disclosed to and used by the following individual(s) or organization(s) (please include the name and address of the individual or organization):

   _____
6. This information is being disclosed for the following purpose(s): _____
7. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to MedHealth, 3400 W. Wheatland Rd,+ Suite 453, Dallas, TX 75237. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
8. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

   _____

   This authorization will expire 12 months from the date of signing.
9. I understand that my treatment, payment, or eligibility to file to insurance company will not be conditional on the completion and signature of this form.
10. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.
11. I understand that I will be given a copy of this authorization form after signing.

_____ _____

Signature of Patient/Responsible Party or Legal Representative Date

_____

If Signed by Legal Representative, Relation to Patient

Methodist MEDICAL GROUP

Patient History Form

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

Please tell us why you are here to see the doctor today: _____

_____

Check illness that applies to you:

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Nephritis
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Lung Problems
- ☐ Tuberculosis
- ☐ Epilepsy
- ☐ Arthritis
- ☐ Cancer – If yes, what type?
- ☐ Stomach or Colon Problems
- ☐ Mitral Valve Prolapse
- ☐ Vascular Disease
- ☐ Other _____

Do you currently smoke cigars, cigarettes, pipes, or other? _____ If yes, how much? _____

Have you previously smoked cigars, cigarettes, pipes, or other? _____ If yes, when did you quit? _____

Do you currently consume alcohol? _____ If yes, how much and how often? _____

Do you have any food allergies? _____ If yes, please list: _____

Do you have any drug allergies? _____ If yes, please list: _____

Are you allergic to LATEX? _____ If yes, what is your reaction _____

Do you have a pacemaker or defibrillator? _____ If so, what brand? _____

What surgeries have you had in the past? _____

_____

If so, did you have any complications from bleeding or anesthesia? _____

Have you ever been hospitalized for any serious injury or other illnesses? _____

If yes, please explain: _____

Have you ever been advised to have a surgery that has not yet been done? _____

If yes, please explain: _____

Have you had a recent colonoscopy? □N/A □ No □ Yes If yes, when? _____

Have you had a recent mammogram? □ N/A □ No □ Yes If yes, when? _____

Have you had a recent pap smear? □ N/A □ No □ Yes if yes, when? _____

Methodist MEDICAL GROUP

Patient History Form

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

List Medications (**Prescribed and over the counter!)**
Please only list ACTIVE medications, not medications prescribed or taken in the past
IF NO MEDICATIONS PLEASE WRITE "NONE"

Medication Name and Dosage	Frequency

Signature_____ Date_____

Methodist MEDICAL GROUP

Patient Health Questionnaire

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

Over the last 2 weeks, how often have you been bothered by the following problems?	**Yes**	**No**
1. Little interest or pleasure in doing things	☐	☐
2. Feeling down, depressed or hopeless	☐	☐

If you ***answered yes***, to one of the questions above please respond to the questions below:

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed or hopeless	☐	☐	☐	☐
3. Trouble falling asleep, staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself	☐	☐	☐	☐