

Diabetes and Thyroid Center of Fort Worth, PLLC

HISTORY QUESTIONNAIRE

Name: _____ DOB: _____ Today's Date: _____

Reason for visit: _____

S O C I A L	Marital Status: [Single] [Married] [Widowed ___/___/___] [Divorced ___/___/___]		
	Occupation: [Retired] [Active] _____		
	Do you: {Please circle No or Yes and explain if Yes}		
	Get exercise	[No] [Yes] ⇨	hours per week: _____ type of exercise: _____
	Use illegal drugs	[No] [Yes] ⇨	_____
	Use alcohol	[No] [Yes] ⇨	ounces per day _____
P A S T M E D I C A L	Use tobacco [No] [Yes] ⇨ _____ packs per day for _____ years _____ current _____ past		
	What medications are you currently taking (include supplements and vitamins)? Please list dose and frequency.		

	Have you had previous surgeries:		

Problems for which you have seen a physician or have been treated for: (use back of page if necessary)			
Diabetes	[No] [Yes] ⇨	Type _____ Year _____ Treatment _____	
Cancer	[No] [Yes] ⇨	Type _____ Year _____ Treatment _____	
Nodule/Tumor	[No] [Yes] ⇨	Location _____ Year _____ Treatment _____	
Cholesterol	[No] [Yes] ⇨	Meds _____ Side effects? _____	
Stroke	[No] [Yes] ⇨	Year _____ Treatment _____	
Blood pressure	[No] [Yes] ⇨	Year _____ Medications _____	
Heart problem	[No] [Yes] ⇨	Year _____ Treatment _____	
Eye disease	[No] [Yes] ⇨	Diabetic? _____ Year _____ Treatment _____	
Kidney disease	[No] [Yes] ⇨	Diabetic? _____ Year _____ Treatment _____	
Foot infections	[No] [Yes] ⇨	Diabetic? _____ Year _____ Treatment _____	
Thyroid disease	[No] [Yes] ⇨	Type _____ Year _____ Treatment _____	
Others	[No] [Yes] ⇨	_____	
Do you have any allergies/reactions? {please list reaction}			

F A M I L Y	Do any of your blood relatives have or have had any of these diseases or...		
	Do any other problems run in the family:		
	Diabetes	[No] [Yes] ⇨	Type: _____
	Cancer	[No] [Yes] ⇨	Location: _____
	Tumor/lesion	[No] [Yes] ⇨	Location: _____
	Heart problem	[No] [Yes] ⇨	_____
	TB	[No] [Yes]	
	Thyroid disease	[No] [Yes]	Type: _____
	High blood pressure	[No] [Yes]	_____
	Stroke	[No] [Yes]	_____

Diabetes and Thyroid Center of Fort Worth, PLLC
Darren Lackan, MD, PA Chris Bajaj, DO, PA
Anjanette Tan, MD, PA

REGISTRATION FORM

(Please Print)

Today's Date:					
PATIENT INFORMATION					
Patient's Last Name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss	Marital Status (circle one)
				<input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Single / Mar / Div / Sep / Wid
Nickname:	Former Name:		Birth Date:	Age:	Sex:
			/ /		<input type="checkbox"/> M <input type="checkbox"/> F
Street Address:			City:	State:	ZIP Code:
Social Security #:		Home Phone #:		Cell Phone #:	
		()		()	
Occupation:	Employer:			Employer Phone #:	
				()	
Referred to clinic by:			Email address:		
GUARANTOR INFORMATION					
<input type="checkbox"/> Check if same as patient information					
Person responsible for bill:		Birth Date:	Address (if different):	Home Phone #:	
		/ /		()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Social Security #:	Employer:		Employer address:	Employer #:	
				()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
INSURANCE INFORMATION					
Primary Insurance:			Subscriber's Name:		
Subs. Social Security #:	Birth Date:			Co-payment:	
	/ /				
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:		
Subs. Social Security #:	Birth Date:			Co-payment:	
	/ /				
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:					
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):		Relationship to Patient:	Home Phone #:	Work Phone #:	
			()	()	

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PATIENT NAME: _____

ACCT#: _____

**PATIENT PREFERENCE REGARDING
COMMUNICATION OF HEALTH INFORMATION**

WHO TO CONTACT

I hereby give permission to Diabetes and Thyroid Center of Fort Worth, PLLC to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

Name		Relationship	
Name		Relationship	
Name		Relationship	

I do not wish to give permission for additional family members, relatives, or close personal friends to have access to any information regarding my medical condition(s).

HOW TO CONTACT

Communication by Phone

Home Telephone: ()

Work Telephone: ()

<input type="checkbox"/>	Okay to leave message with detailed information	<input type="checkbox"/>	Okay to leave message with detailed information
<input type="checkbox"/>	Leave message with call-back number only	<input type="checkbox"/>	Leave message with call-back number only

Written Communication

<input type="checkbox"/>	Okay to mail to my home address:
<input type="checkbox"/>	Okay to mail to my work address:
<input type="checkbox"/>	Okay to fax to this number:

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

Patient or
Parent/Guardian Signature: _____

Date: _____

DIABETES AND THYROID CENTER OF FORT WORTH
DARREN LACKAN, MD, PA
CHRIS BAJAJ, DO, PA
ANJANETTE TAN, MD, PA
NOTICE OF HEALTH INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record/Information

This notice describes the practices of Diabetes and Thyroid Center of Fort Worth (DTC) and that of its physicians with respect to your protected health information created while you are a patient at DTC. DTC physicians and personnel authorized to have access to your medical chart are subject to this notice. In addition, DTC physicians may share medical information with each other for treatment, payment or health care operations described in this notice.

We create a record of the care and services you receive at DTC. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the records of your care at DTC.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

Your Health Information Rights

Although your health record is the physical property of DTC, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information for treatment, payment, health care operations and as to disclosures permitted to persons, including family members involved with your care and as provided by law. However, we are not required by law to agree to a requested restriction;
- Obtain a paper copy of this notice of information practices;
- Inspect and request a copy of your health record as provided by law;
- Request that we amend your health record as provided by law. We will notify you if we are unable to grant your request to amend your health record;
- Obtain an accounting of disclosures of your health information as provided by law;
- Request communication of your health information by alternative means or at alternative locations. We will accommodate reasonable requests; and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken in reliance on your authorization.

You may exercise your rights set forth in this notice by providing a written request, except for requests to obtain a paper copy of the notice, to Diabetes and Thyroid Center of Fort Worth, 7801 Oakmont Blvd., Suite 101, Fort Worth, TX, 76132.

Our Responsibilities

In addition to the responsibilities set forth above, we are also required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on certain uses and disclosures;
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change. Should our information practices change we are not required to notify you, but we will have the revised notice available for you to request at DTC.
- We will not use or disclose your health information without your written authorization, except as described in this notice

Examples of Disclosures for Treatment, Payment, Health Care Operations, and As Otherwise Allowed By Law.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information should fall within one of the categories

We will use your health information for treatment.

For example: We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at DTC. We may share medical information about you in order to coordinate different treatments, such as prescriptions, lab work and x-rays. We may also provide your physician or a subsequent health-care provider with copies of various reports to assist in treating you once you are discharged from care at DTC.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health care operations.

For example: We may use the information in your health record to assess the care and outcome in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

We will use your health information as otherwise allowed by law. The following are some examples of how we may use or disclose medical information about you.

Business associates: There are some services provided in our organization through agreements with business associates. Examples include answering services and copy services. To protect your health information, however, we require business associates to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research

proposal and established protocols to protect the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Communications for treatment and health care operations: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fundraising: We may contact you as part of a fundraising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, medications, devices, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Worker's Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse, neglect or domestic violence: As required by law, we may disclose health information to a governmental authority authorized by law to receive reports of abuse, neglect, or domestic violence.

Judicial, administrative, and law enforcement purposes: Consistent with applicable law, we may disclose health information about you for judicial, administrative, and law enforcement purposes.

Required or allowed by law: We will disclose medical information about you when required or allowed to do so by federal, state, or local law.

For More Information or to Report a Problem

If you have questions or would like additional information, you may contact Enterprise Medical Management at 866-459-7818. If you believe your privacy rights have been violated, you can file a complaint with Enterprise Medical Management or the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

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ACKNOWLEDGEMENT OF THE RECEIPT OF DIABETES AND THYROID CENTER OF FORT WORTH (DTC)
NOTICE OF HEALTH INFORMATION PRACTICES

Patient's Name: _____

ACKNOWLEDGEMENT

Revision date: April 13, 2003

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

DTC is furnishing you with the attached notice, which provides information about how DTC and its physicians may use and/or disclose protected information about you for treatment, payment, healthcare operations and as otherwise allowed by the law. By signing this form, you acknowledge that you have received a copy of Notice of Health Information Practices.

Patient/Guardian Signature: _____ Date: _____

CONSENT TO TREAT

I hereby authorize employees and agents; including physicians of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates, and assistants of the physician's choice.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

Patient/Guardian Signature: _____ Date: _____

FOR MINORS

If the patient is a minor:

I consent for _____ to authorize evaluation and treatment for my child named herein when I am not available. I understand that this authorizes the person(s) named above to consent to medical and surgical procedures and immunizations for the child named herein.

Patient/Guardian Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY

I hereby authorize payment of medical benefits directly to DTC and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim. I understand that this authorization may include release of information regarding communicable disease, such as Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to DTC. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expenses of DTC, if any. I also understand that interest may be charged at a rate of 11% per annum for accounts over 60 days old. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

Patient/Guardian Signature: _____ Date: _____