

## Corridor Primary Care, P.A. Patient History Form

Name (Please print): \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Form completed by: \_\_\_\_\_ Today's date: \_\_\_\_\_

**ALLERGIES** (List substance and reaction)

Drugs \_\_\_\_\_

Food \_\_\_\_\_

Other (bees, latex, vaccines, etc.) \_\_\_\_\_

**MEDICATIONS I TAKE** (List prescriptions and over-the-counter products – use other side if necessary)

Name	Dose/How often	Name	Dose/How often
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**MEDICAL HISTORY**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> High blood pressure                            | <input type="checkbox"/> Diabetes with insulin    | <input type="checkbox"/> Osteoarthritis                  |
| <input type="checkbox"/> High cholesterol                               | <input type="checkbox"/> Diabetes without insulin | <input type="checkbox"/> Rheumatoid/other arthritis      |
| <input type="checkbox"/> Heart disease                                  | <input type="checkbox"/> Thyroid: High? Low?      | <input type="checkbox"/> Gout                            |
| <input type="checkbox"/> Stroke or Mini-stroke (TIA)                    | <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Fibromyalgia                    |
| <input type="checkbox"/> Blood clot                                     | <input type="checkbox"/> Sleep apnea              | <input type="checkbox"/> Connective tissue disease       |
| <input type="checkbox"/> Heart murmur                                   | <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Osteoporosis                    |
| <input type="checkbox"/> Irregular heartbeat                            | <input type="checkbox"/> Emphysema/COPD           | <input type="checkbox"/> Peripheral nerve disease        |
| <input type="checkbox"/> Heart failure                                  | <input type="checkbox"/> Positive TB test         | <input type="checkbox"/> Liver disease                   |
| <input type="checkbox"/> Enlarged prostate                              | <input type="checkbox"/> Diverticulitis           | <input type="checkbox"/> Kidney disease                  |
| <input type="checkbox"/> Erectile dysfunction                           | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Kidney stones                   |
| <input type="checkbox"/> Frequent urinary infections                    | <input type="checkbox"/> Acid reflux/GERD         | <input type="checkbox"/> Seizures                        |
| <input type="checkbox"/> Overactive bladder                             | <input type="checkbox"/> Bleeding ulcer           | <input type="checkbox"/> Memory loss/Dementia            |
| <input type="checkbox"/> Glaucoma                                       | <input type="checkbox"/> Hearing loss             | <input type="checkbox"/> Migraines: with aura? Yes No    |
| <input type="checkbox"/> Macular degeneration                           | <input type="checkbox"/> Depression               | <input type="checkbox"/> Blood transfusion (when?) _____ |
| <input type="checkbox"/> Abuse  | <input type="checkbox"/> Anxiety                  | <input type="checkbox"/> Other:                          |
| <input type="checkbox"/> STI: Type?                                     | <input type="checkbox"/> Hepatitis (type?)        | (treatment?) _____                                       |
| <input type="checkbox"/> ADD/ADHD: When Diagnosed? _____ By whom? _____ |   |  |
| <input type="checkbox"/> Vitamin Deficiency: Types? _____               |   |  |
| <input type="checkbox"/> Hormone Deficiency: Types? _____               |   |  |
| <input type="checkbox"/> Cancer: Types? _____                           |   |  |
| <input type="checkbox"/> Serious Injuries: Types? _____                 |   |  |
- List any **SPECIALISTS** you see: \_\_\_\_\_
- List any **SURGERIES** you have had: \_\_\_\_\_

**FAMILY HISTORY** (list who: Mother, Father, Maternal/Paternal Grandparents, Brother, Sister or Child)

High Blood Pressure \_\_\_\_\_ Diabetes Type 1 \_\_\_\_\_ Stroke \_\_\_\_\_  
High Cholesterol \_\_\_\_\_ Diabetes Type 2 \_\_\_\_\_ Alzheimer's \_\_\_\_\_  
Heart Disease \_\_\_\_\_ Osteoporosis \_\_\_\_\_ Colon Cancer/Polyps \_\_\_\_\_  
Breast Cancer \_\_\_\_\_ Prostate Cancer \_\_\_\_\_  
Other Cancer (Type?) \_\_\_\_\_ Psychiatric Disorder \_\_\_\_\_  
Thyroid Disease \_\_\_\_\_ Other inherited problems \_\_\_\_\_

**SOCIAL HISTORY** (Check all that apply)

- Single
- Married: How long? \_\_\_\_\_
- Divorced: When? \_\_\_\_\_
- Widowed: When? \_\_\_\_\_
- Partnered: How long? \_\_\_\_\_
- Number of children: \_\_\_\_\_
- Faith preference: \_\_\_\_\_
- Hobbies/Interests: \_\_\_\_\_
- Current/Former occupation: \_\_\_\_\_
- Last grade level attended: \_\_\_\_\_

Are you a:

- Student? Where: \_\_\_\_\_
- At home caregiver? For whom: \_\_\_\_\_
- Employed? \_\_\_\_\_
- Disabled? Cause: \_\_\_\_\_
- Did you move here from another country?  
Country(s): \_\_\_\_\_
- I have an Advance Directive document

**HEALTH HABITS**

Never used tobacco  Use e-cigarettes

Use tobacco now: Type(s) \_\_\_\_\_ ; #packs/containers daily \_\_\_\_\_ ; #years/age you started \_\_\_\_\_

Quit tobacco: Type(s) \_\_\_\_\_ Date/Age quit \_\_\_\_\_ ; #years used/age you started \_\_\_\_\_

Alcohol? Type(s) \_\_\_\_\_ ; #drinks/week \_\_\_\_\_ ; #years/age started \_\_\_\_\_

Recreational substances? Currently using \_\_\_\_\_  
Formerly used \_\_\_\_\_ Treatment required (circle)? Yes No

Exercise routine (describe)? None, or \_\_\_\_\_

Special diet? \_\_\_\_\_

Other regular healthcare practices? \_\_\_\_\_

**IMMUNIZATIONS** - Please write the date of your most recent vaccine (if known)

Influenza \_\_\_\_\_ Tetanus \_\_\_\_\_ Meningitis \_\_\_\_\_ Shingles \_\_\_\_\_

Pneumonia \_\_\_\_\_ Have you had 2 of these? No Yes

Hepatitis A \_\_\_\_\_ Have you completed the series of 2? No Yes

Hepatitis B \_\_\_\_\_ Have you completed the series of 3? No Yes

HPV (Gardasil) \_\_\_\_\_

**SCREENING TESTS** - Please write the date of your most recent test (if known)

Chest X-ray \_\_\_\_\_ Colonoscopy \_\_\_\_\_ EKG \_\_\_\_\_

Bone Density \_\_\_\_\_ Sleep study \_\_\_\_\_ Lung Function \_\_\_\_\_

To the best of my knowledge the statements and answers on this form are true, complete and correct.

\_\_\_\_\_  
Patient or Guardian's signature

\_\_\_\_\_  
Date

**WOMEN ONLY**

Type of contraception used (If applicable): \_\_\_\_\_

Date of last menstrual period \_\_\_\_\_

How many times have you been pregnant? \_\_\_\_\_

Age your periods began \_\_\_\_\_

Number of deliveries: Vaginal \_\_\_\_ C-Section \_\_\_\_

Are your periods regular? Yes No

Any Tubal Pregnancies? Yes No

Are your periods Heavy Moderate Light

Miscarriages Yes No

Are your cramps Severe Mild None

Stillbirths Yes No

Date of last Pap smear \_\_\_\_\_

Abortions Yes No

Date of last mammogram \_\_\_\_\_

Complications with pregnancies? Yes No

Do you check your breasts monthly? Yes No

Any abnormal vaginal discharge? Yes No

To the best of my knowledge the statements and answers on this form are true, complete and correct.

\_\_\_\_\_  
Patient or Guardian's signature

\_\_\_\_\_  
Date

Please return to receptionist or nurse when completed and signed. Thank you

Corridor Primary Care Internal Medicine  
Patient Information

Date \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Patient Name \_\_\_\_\_ Gender: M F

Date of Birth \_\_\_\_\_ SS # \_\_\_\_\_

Email: \_\_\_\_\_

Local Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

Cell/Alternate \_\_\_\_\_

Permanent Address (if different):

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

Marital Status: Single Married Divorced Widowed Partnered

Spouse/Partner Name \_\_\_\_\_

Spouse/Partner Contact # \_\_\_\_\_

Parent/Guardian Name(s) \_\_\_\_\_

Parent/Guardian Contact # \_\_\_\_\_

Race: Hispanic African-American White/Hispanic Asian

Primary Ethnic group: Hispanic/Latino or Non-Hispanic/Latino

Preferred Language(s) \_\_\_\_\_

Is a relative a patient of this clinic? If yes, please write name: \_\_\_\_\_

I authorize CPC to share medical information with the following people: Please indicate if emergency contact by circling the (E).

Name \_\_\_\_\_ Contact # \_\_\_\_\_ Relation \_\_\_\_\_ (E)

Name \_\_\_\_\_ Contact # \_\_\_\_\_ Relation \_\_\_\_\_ (E)

Name \_\_\_\_\_ Contact # \_\_\_\_\_ Relation \_\_\_\_\_ (E)

Completed by (Sign:)

\_\_\_\_\_

Corridor Primary Care, P.A.  
Internal Medicine  
Financial Policies

Charges for medical services are due at the time services are rendered. Payment may be made with cash, check or credit card. Patients covered under PPO or HMO policies must pay copays/deductibles/coinsurances at the time of service. We will file your insurance claims as a courtesy to you. If your insurance carrier does not pay your account within 60 days of service, you will be responsible for payment. If Corridor Primary Care (CPC) doctors are not providers under your plan, payment is expected at the time of service and the claim will be filed as unassigned. Payment arrangements can be made with the office manager if you are unable to pay your full balance due. Please ask to speak to the office manager at the time of your visit. Balances past due over 90 days will be collected by a collection agency.

Medicare patients

CPC accepts Medicare assignment. We will file all services performed in our office with the exception of lab work. Lab work is provided by independent labs. Supplemental policies will be filed if you provide our office with correct policy information. Supplemental claims returned due to incorrect information will be forwarded to the patient. Payment for services considered NON-COVERED by Medicare will be due at the time of such service.

PPO/HMO patients

CPC participates in many insurance plans. It is the patient's responsibility to verify that the CPC doctor is in your particular plan. To obtain a referral for specialist care, you must give us three (3) days notice prior to your specialist's appointment. The insurance plans will not allow us to "back date" referral authorizations. Payment for non-covered services is due at the time of such service. Please tell the staff if you have preventative or wellness benefits coverage.

Assignment of Benefits

I hereby assign medical and/or surgical benefits to include major medical benefits to which I am entitled, payable to Corridor Primary Care, P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered valid as an original. I understand I am financially responsible for all non-covered charges, deductibles, copays and coinsurance balances due. I have read the financial policies of CPC listed above. I authorize said assignee to release all information necessary to secure payment.

Name (please print) \_\_\_\_\_

Date of Birth \_\_\_\_\_

Signature

Date

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CORRIDOR PRIMARY CARE INTERNAL MEDICINE

601A Leah Avenue  
San Marcos, Texas 78666  
Gregory K. Moore, M.D.

Date:

Patient: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

I understand that Corridor Primary Care has a Nurse Practitioner on staff.

Nurse practitioners are registered nurses with advanced academic and clinical education in family health care, pharmacology, development throughout the life cycle, and family dynamics.

FNP's provide the following care:

- Physical exams
- Diagnose and treat common acute illnesses
- Provide management and counseling
- Serve as advocates
- Monitor chronic illness and conditions

I understand that I may be offered appointments for sick or well care with a nurse practitioner. I understand that I can refuse an appointment with a nurse practitioner. I understand that it is my responsibility to know if my appointment is with a physician or nurse practitioner. I agree to be treated by a nurse practitioner if I schedule an appointment with one.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

## Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority

# Notice of Privacy 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.**

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact the office manager

## **Treatment, Payment, Health Care Operations**

### **Treatment**

We are permitted to use and disclose your medical information to those involved in your treatment. For example, your care may require the involvement of a specialist. When we refer you to a specialist, we will share some or all of your medical information with that physician to facilitate the delivery of care.

### **Payment**

We are permitted to use and disclose your medical information to bill and collect payment for the services provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to approve payment to us.

### **Health Care Operations**

We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. [For example, we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law.] OR

[For example, we may ask another physician to review this practice's charts and medical records to evaluate our performance so that we may ensure that only the best health care is provided by this practice.]

## **Disclosures That Can Be Made Without Your Authorization**

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

## **Public Health, Abuse or Neglect, and Health Oversight**



We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

#### **Legal Proceedings and Law Enforcement**

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

- Is released pursuant to legal process, such as a warrant or subpoena;
- Pertains to a victim of crime and you are incapacitated;
- Pertains to a person who has died under circumstances that may be related to criminal conduct;
- Is about a victim of crime and we are unable to obtain the person's agreement;
- Is released because of a crime that has occurred on these premises; or
- Is released to locate a fugitive, missing person, or suspect.

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

#### **Workers' Compensation**

We may disclose your medical information as required by the Texas workers' compensation law.

#### **Inmates**

If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

#### **Military, National Security and Intelligence Activities, Protection of the President**

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence

activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

### **Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors**

When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

### **Required by Law**

We may release your medical information where the disclosure is required by law.

### **Your Rights Under Federal Privacy Regulations**

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

### **Requested Restrictions**

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

To request a restriction, submit the following in writing: (a) The information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and (c) to whom the limits apply. Please send the request to the address and person listed below.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

### **Receiving Confidential Communications by Alternative Means**

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

### **Inspection and Copies of Protected Health Information**

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed below.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

- Includes psychotherapy notes.
- Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.
- Is subject to the Clinical Laboratory Improvements Amendments of 1988.
- Has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the *lower* of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

#### **Amendment of Medical Information**

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Wasn't created by this practice or the physicians here in this practice.
- Is not part of the Designated Record Set?
- Is not available for inspection because of an appropriate denial.
- If the information is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

#### **Accounting of Certain Disclosures**

The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request *before* any costs are incurred.

#### **Appointment Reminders, Treatment Alternatives, and Other Health-related Benefits**

We may contact you by [telephone, mail, or both] to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

### **Complaints**

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services  
HIPAA Complaint  
7500 Security Blvd., C5-24-04  
Baltimore, MD 21244

### **Our Promise to You**

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

### **Questions and Contact Person for Requests**

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Michelle Comstock  
601B Leah Avenue  
San Marcos, Texas 78666  
512-392-1700

This notice is effective on the following date: April 14, 2003

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.