ELDORADO
FAMILY MEDICINE
YOUR TRUSTED PRIMARY CARE
P:214-592-8382 | F:214-592-8206

NEW PATIENT PAPERWORK

Today's Date _____ **Today's Visit Reason** _____

First Name _____ **Last Name** _____

Home Address _____

City _____ **State** _____ **Zip Code** _____

Cell # _____ **Email** _____

Date of Birth _____ **Marital Status** Divorced Married Single Widow

Sex Female Male **Occupation** _____

Other Patient Information-Circle all that are applicable

Race Africa American Asian Asian Indian Native American Pacific Islander White Declined Other _____

Ethnicity Hispanic/Latino Non-Hispanic/Latino Declined Other _____

Emergency Contact Name _____

Emergency Contact Relationship _____ Cell# _____

Involvement of Others in Care: I authorize EFM and it's staff to discuss my/the patient's care and medical needs with the following persons:

Name	Date of Birth	Relationship	Phone Number

☐ I **DO NOT** wish to add any additional contact person to discuss my/the patient's needs.

How May We Contact You By Phone and Leave a Message About Your Care?

Main Phone # _____

- ☐ Leave message with contact number only.
- ☐ Leave message with detailed information.
- ☐ Do not leave message.

Other Phone# _____

- ☐ Leave message with contact number only.
- ☐ Leave message with detailed information.
- ☐ Do not leave message.

PHARMACY (List the pharmacy most frequently used for prescriptions. We will only have one pharmacy on file at a time and we will only send the pharmacy listed.)

Name: _____ Phone # _____

Address _____ City _____

GENERAL CONSENT FORM

Today's Date _____

Patient's Name _____ **Date of Birth** _____

Read every section on this form and initial after each statement that you understand and agree to the information.

Assignment of Benefits: I authorize Eldorado Family Medicine, ("EFM") to submit claims on my behalf directly to my health insurance carrier. This means that EFM will collect payment for all supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid by the insurance company. I authorize you to release any information necessary to my insurance company, regarding illnesses and treatment to process claims. This assignment will remain in effect until revoked by me in writing.

Patient's Initials _____

Consent for Treatment: I consent for EFM to administer and/or order treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives.

Patient's Initials _____

Electronic Prescription: I understand EFM utilizes electronic prescribing and if my pharmacy does not offer electronic prescribing, I understand that EFM will either given me a hard copy or will fax my prescriptions I understand that Dr.Lin does not write prescriptions for controlled medications or narcotics on a regular basis, however, if he does write one he will first check my prescription history with the Texas Prescription Monitoring Program (TPMP) online portal. Dependent upon my history of controlled prescriptions, or information that is obtained via the pharmacy, EFM reserves the right to cancel a controlled substance prescription.

Patient's Initials _____

Electronic Records: I understand EFM utilizes electronic records that are accessible via the Patient Portal, and the Healow app. I understand that all of my lab results will be available on the patient portal after they have been reviewed with me either by phone or appointment and will not be printed in the office except in extenuating circumstances. I understand that I can communicate with the staff and access my records via my patient portal. I understand that by providing my email address I am opting in to my patient portal as well as granting my permission to access my records from other providers electronically.

Email _____ **Patient's Initials** _____

Phone Calls: By providing contact information, I authorize EFM, its assignees, and third party collection agents to use the contact information I have provided to communicate with me and to place calls to my home or cell phone; leave voice or text messages; and use pre-recorded/artificial/voice messages in connection with any communication to me.

_____

Patient's Initials

GENERAL CONSENT FORM-CONTINUED

Today's Date _____

Patient's Name _____ **Date of Birth** _____

Patient Financial Policy

I acknowledge the receipt of the "Patient Financial Policy." **Patient's Initials** _____

Notice of Privacy Practices

I acknowledge the receipt of the "Notice of Privacy Practices." **Patient's Initials** _____

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name of Patient or Personal Representative and Relationship if not the patient

Tests/Immunization	Last Date Completed
Eye Exam	
Pulmonary Function Test	
Echocardiogram/EKG	
Cardiac Stress Test	
Mammogram	
Bone Density Test/Dexa Scan	
Diabetic Foot Exam	
Colonoscopy/ColoGuard/FIT card	
PAP Smear/Well Woman's Exam	
Influenza/Flu Vaccine	
Pneumonia Vaccine(s)	
Tetanus Vaccine	
Blood Transfusion	
Last Dental Exam	
Last Prostate Exam	
Most Recent Bloodwork	
Last Physical	

List ALL other medical providers (Primary Care, Specialists, and others) you are currently seeing or have seen in the past. Format Name, Specialty, year seen. (i.e. Dr. Tom Johnson-Cardiologist-2020 etc):

_____

_____

MEDICAL HISTORY FORM

Today's Date _____

Patient's Name _____ **Date of Birth** _____

MEDICAL HISTORY-Past or Present (Please list all conditions that you have had or currently have. You can attach an additional sheet if needed)

Condition	Date Diagnosed	Treatment	Date Resolved

ALLERGIES (include medication, foods, x-ray dyes) **No Known Allergies** ☐

Name of allergen (i.e. Lisinopril)	Type of reaction (i.e. rash)	Date started

CURRENT MEDICATIONS (Attach an extra sheet if needed) **None** ☐

Name of medication (i.e. Metformin)	Dose (i.e. 500 mgs)	How often taken (i.e. Twice a day)	Reason for taking/Current Diagnosis (i.e.	Name of Doctor prescribing

PREVIOUS HOSPITALIZATIONS (include all non surgical hospitalizations. Attach an extra sheet if needed) **None** ☐

Reasons for hospital stay	**Date (approximate)**	**Hospital Name**

SURGERIES (include all surgeries or procedures in your lifetime. Attach an extra sheet if needed) **None** ☐

Surgery or Procedure	**Date (approximate)**	**Hospital or Surgeon Name**

MEDICAL HISTORY FORM-CONTINUED

Today's Date _____

Patient's Name _____ **Date of Birth** _____

FAMILY HISTORY (List all family history. Attach an extra sheet if needed)			**None** ☐
Relative	**Significant Medical Problem**	**Age at Diagnosis** age	**Current Age** (or when deceased)
Father			
Mother			
Children			
Brother			
Sister			
Grandfather	Maternal Paternal		
Grandmother	Maternal Paternal		
Aunts			
Uncles			

OB/GYN HISTORY: # of Pregnancies _____ # of Deliveries _____ Last Menstrual Cycle _____

TOBACCO HISTORY (Circle Yes or No)

Are you an active cigarette smoker? Yes No

Have you ever been a cigarette smoker? Yes No ☐

If yes, I smoked an average of: _____ packs a day for _____ years.

What year did you quit smoking. _____

Do you use other tobacco products? Yes No

If yes, please specify what you use: _____

ALCOHOL AND DRUG HISTORY (Circle Yes or No)

Have you ever been diagnosed with alcoholism? Yes No

Do you currently drink alcohol regularly? Yes No

If yes, approximately how many drinks per week (beer, wine, or liquor)

Have you ever used intravenous drugs? Yes No

Have you ever used any drugs? Yes No

If yes, what type of drugs have you used and when? _____