Primary Care Clinic of North Texas

Patient Information

First Name_____ Last Name _____
(Nombre Del Paciente) *(Apellido)*

Sex *(Sexo)*: ☐ Male ☐ Female Date of Birth *(Fecha de Nacimiento)*: _____/_____/_____

Email_____ Cell Phone_____ Home Phone_____
(El correo electrónico) *(Cellular)* *(Numero de casa)*

Address_____
(Dirección de casa)

City _____State _____ Zip _____
(Ciudad) *(Estado)* *(Código Postal)*

Emergency Contact *(Contacto de Emergencia)*

Name *(Nombre)* _____

Relationship *(Relacion)* _____

Phone Number *(Numero de Telefono)* _____

Demographics *(Datos Demográficos)*

Race *(Raza)* ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other: _____

Ethnicity *(Etnicidad)* ☐ Hispanic or Latino ☐ Non-Hispanic/Latino

Marital Status *(Estato Civil)* ☐ Single *(Soltera/o)* ☐ Married *(Casada/o)* ☐ Divorced *(Divorciada/o)* ☐ Widowed *(Viuda/o)*

Pharmacy Information *(Información de la Farmacia)*

Name *(Nombre)* _____

Location *(Ubicación)* _____

Phone Number *(Número de teléfono)* _____

Other Patient Information *(Otra información del paciente)*

Do you currently have health insurance? ☐ Yes ☐ No Are you a veteran? ☐ Yes ☐ No
(¿Tienes seguro medico?) *(¿Eres un veterano?)*

Care giver for veteran? ☐ Yes ☐ No Spouse or child of a veteran? ☐ Yes ☐ No
¿Eres cuidador/a de una veterana? *¿Es usted cónyuge o hija/o de un veterano?*

How did you hear about us? _____
(¿Como supiste de nosotros?)

_____ _____
Patient/Guardian Signature *(Firma del Paciente)* Date *(Fecha)*

HISTORY & PHYSICAL
(PLEASE PRINT)

DATE: ___/___/___

Name:_____ male___ female:___ Marital status_____
Address:_____ Phone:(h)_____(w)_____
Occupation:_____ Employer:_____

Family History: If any blood relative has suffered any of the following, please circle the number & indicate which relative.

1. epilepsy
2. migraine
3. mental ill
4. glaucoma
5. diabetes
6. thyroid
7. hay fever
8. asthma
9. anemia
10. bleeds easily
11. osteoporosis
12. arthritis
13. heart disease
14. stroke
15. hypertension
16. alcoholism_____
17. cancer_____
18. _____
19. _____
20. _____

Hospital Admissions— year of illness or operation _____
(not including pregnancies)

List all medications you are now taking: _____

Allergies _____ Vaccine-yr _____ Test/Exam-yr _____

Medical History: Mark (c) for current problems. Check (x) and indicate age when you had any of the following symptoms or diseases.
Main Problems: 1) _____ 2) _____ 3) _____

[ ] diabetes
[ ] alcohol
[ ] seizures
[ ] stroke
[ ] smoking
[ ] heartburn
[ ] dizzy spells
[ ] eye pain
[ ] arthritis
[ ] back pain
[ ] diarrhea
[ ] gout
[ ] foot pain
[ ] hernia
[ ] rashes
[ ] psoriasis
[ ] eczema
[ ] depression
[ ] nervousness
[ ] chest pain
[ ] phobias
[ ] polio
[ ] mumps
[ ] palpitations
[ ] measles
[ ] hives
[ ] osteoporosis
[ ] hemorrhoids

[ ] thyroid disease
[ ] ringing in ear
[ ] peptic ulcer
[ ] fainting spells
[ ] muscle weakness
[ ] failing vision
[ ] rheumatism
[ ] sinus trouble
[ ] constipation
[ ] diverticulosis
[ ] crohn's colitis
[ ] blood in urine
[ ] kidney stones
[ ] memory loss
[ ] venereal disease
[ ] mental illness
[ ] high blood pressure
[ ] urethral discharge
[ ] rheumatic fever
[ ] scarlet fever
[ ] heart murmur
[ ] swollen ankles
[ ] chronic fatigue
[ ] chicken pox
[ ] irregular pulse
[ ] german measles
[ ] weight loss-recent
[ ] decreased hearing

[ ] loss of appetite-recent
[ ] difficulty swallowing
[ ] cig./day__yrs.__Yr. quit____
[ ] alcohol_____oz. per week
[ ] ear infections-frequent
[ ] tremor/hands shaking
[ ] persistent nausea/vomiting
[ ] coffee/tea____ cups pre day
[ ] abdominal pain-chronic
[ ] numbness/tingling sensations
[ ] double or blurred vision
[ ] gall bladder trouble
[ ] headaches-frequent
[ ] eye infections-frequent
[ ] jaundice/hepatitis
[ ] change in bowel habits
[ ] bone fx/joint inj
[ ] recurrent back pain
[ ] sore throats-frequent
[ ] hayfever/allergies
[ ] bloody or tarry stools
[ ] cold numb feet
[ ] hoarseness-prolonged
[ ] pneumonia/pleurisy
[ ] urine infections-frequent
[ ] urination-[ ]overnight > than twice
[ ] painful [ ] on excretion—
[ ] decrease in force/flow

[ ] sleeping-difficulty
[ ] asthma/wheezing
[ ] shortness of breath
[ ] on excretion [ ] lying flat
[ ] varicose veins/phlebitis
[ ] moodiness-excess
[ ] weight loss-recent
[ ] leg pain-when walking
[ ] anemia
[ ] bruise easily
[ ] tuberculosis
[ ] herpes
[ ] nose bleeds-recurrent
[ ] cancer
[ ] bronchitis/chronic cough

Menstrual Flow: [ ] Reg. [ ] Irreg
[ ] pain/cramps [ ] days of flow____
Length of cycle _____
Date – 1st day of last period _____
[ ] pain/bleeding during or after sex __

Number of Pregnancies_____ Abortions_____ Miscarriages_____ Live Births_____
Birth Control Method: B.C. Pill (name)_____ [ ] flushing/menopause
Date of last PAP test_____ [ ] normal [ ] abnormal
Date of last mammogram _____ [ ] normal [ ] abnormal

Lion's Clinic of Texas, Inc.
DBA: Primary Care Clinic of North Texas

www.primarycareclinic.org

Waiver of Liability

I am aware that many of the Physicians and Health Care Practitioners working at the Primary Care Clinic of North Texas locations are "Volunteer Health Care Providers". Their care is not administered for nor with the expectation of compensation, and thus they are immune from civil liability for any act done in good faith and within the scope of their licenses or for any omissions not attributable to negligence.

In exchange for receiving health care services at the clinic, I further agree to waive any and all rights I may have to recover damages from these practitioners.

Exoneración de Responsabilidad

Soy consciente de que muchos de los médicos y profesionales de la salud que trabajan en la Clínica de Atención Primaria de las ubicaciones del norte de Texas son "Proveedores voluntarios de atención médica". Su atención no se administra ni con la expectativa de compensación, y por lo tanto son inmunes a la responsabilidad civil por cualquier acto realizado de buena fe y dentro del alcance de sus licencias o por cualquier omisión que no sea atribuible a negligencia.

A cambio de recibir servicios de atención médica en la clínica, también acepto renunciar a todos los derechos que pueda tener para recuperar los daños de estos profesionales.

Signature of Patient or Guardian **Firma Del Paciente o del Guarda**	**Date** **Fecha**

Participation in Drug Study
Primary Care Clinic of North Texas

The clinic participates in several clinical drug trials with pharmaceutical companies and would like to offer opportunities to all patients to participate. May we contact you regarding study opportunities in the future?

Participación en el Estudio de Drogas
Primary Care Clinic of North Texas

La clínica participa en varios ensayos clínicos de medicamentos con compañías farmacéuticas y le gustaría ofrecer oportunidades a todos los pacientes para que participen. ¿Podemos contactar con usted con respecto a las oportunidades de estudio en el futuro?

Signature of Patient or Guardian **Firma Del Paciente o del Guarda**	**Signature of Patient or Guardian** **Firma Del Paciente o del Guarda**
Name of Patient (Please Print) **Nombre Del Paciente (Por Favor Impression)**	**Date** **Fecha**

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Acknowledgement of Reviewing Notice of Privacy Protection

I have reviewed the office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that my health information will be handled in accordance it HIPAA. I understand that I am entitled to receive a copy of this document upon request.

_____

Name of Patient (Please Print)
Nombre Del Paciente (Por Favor Impression)

Reconocimiento del Aviso de Revisión de Protección de Privacidad

He revisado el Aviso de prácticas de privacidad de la oficina, que explica cómo se usará y divulgará mi información médica. Entiendo que mi información de salud se manejará de acuerdo con la HIPAA. Entiendo que tengo derecho a recibir una copia de este documento cuando lo solicite.

_____

Date
Fecha

Certification of no Medical Insurance

I,_____,

(Name of Patient)

certify that I have no medical insurance.

_____

Signature of Patient or Guardia006E
Firma Del Paciente o del Guarda

Certificación de no Seguro Médico

Yo,_____,

(Name of Patient)

certifico que no tengo seguro médico.

_____

Date
Fecha

Notice: In the event that the doctor needs a medical test not normally performed by the clinic, the patient will be advised that there may be additional charges/billing.

Aviso: En el caso de que el médico necesite un examen médico que normalmente no realiza la clínica, se le informará al paciente que puede haber cargos / facturación adicionales.

Primary Care Clinic of North Texas
Lewisville Phone: 972-221-6005
Plano Phone: 972-596-6005
Dallas Phone: 214-378-6005

I understand that I have **two weeks** from the date of payment to complete my lab work. Failure to complete my lab work within the allotted time will result in non-refund of payment. Additionally, failure to complete the labs make it difficult for the physician to diagnose the treatment and may impact your prescription refill request.

_____
Printed Name of Patient or Guardian

_____
Signature of Patient or Guardian

_____
Date

Entiendo que tengo **dos semanas** a partir de la fecha de pago para completar mi trabajo de laboratorio. Si no completa mi trabajo de laboratorio dentro del tiempo asignado, no se reembolsará el pago. Además, si no completan los laboratorios, es difícil para el médico diagnosticar el tratamiento y puede afectar su solicitud de recarga de recetas.

_____
Nombre impreso del paciente o tutor

_____
Firma del Paciente o Guardián

_____
Fecha

LIONS CLINIC OF TEXAS INC.,
DBA: PRIMARY CARE CLINIC OF NORTH TEXAS
P.O. BOX 703461, DALLAS, TX 75370,
www.primarycarecclinic.org

I _____ am aware that any additional charges from our external lab service provider are added, I will be fully responsible to pay the remaining balance.

_____ _____

Patients Signature Medical Assistant

_____ _____

Date Date

I _____ am responsible to let the clinic know if I am cancelling my appointment. I am aware that the clinic can charge me with a no call or no show fee for not showing up for an appointment without prior notice of cancellation.

_____ _____

Patient's Signature Medical Assistant

_____ _____

Date Date

Please Note: This is only due to the fact that if another patient needs to be seen they can be scheduled if the appointment has been cancelled or rescheduled in advance.

Lions Clinic of Texas Inc., dba: Primary Care Clinic of North Texas is a non- profit organization under section 501 (c) 3 of the internal Revenue Code. All contrinutions are tax-deductible to the extent allowed by the federal law. This acknowledgement confirms that the organization provided neither goods not services in return for your contribution. You should retain this correspondence for your tax records.