The Vine MEDICAL CENTER

921 E. FM 1187 Ste. A Crowley, TX 76036
Phone: 817-945-1682 Fax: 817-297-4181

6251 Oakmont Blvd. Fort Worth, TX 76132
Phone: 682-250-5700 Fax: 682-250-5705

Name: _____ Date of Birth: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home# _____ Cell# _____ Work# _____

Gender: M F Marital Status: S M W D Social Security: _____- _____ - _____

Email: _____

Emergency contact: _____ Relationship: _____

Emergency contact Phone # _____

Billing Information:

Person responsible for bill: _____ Relationship: _____

Date of Birth: _____ Address (if different from above) _____

Primary Insurance: _____ Relationship to Patient: _____

ID# _____ Group: _____

Secondary Insurance: _____ Relationship to Patient: _____

ID# _____ Group: _____

It is the patient's responsible to pay deductibles, co-insurance and/or co-pays on the day of service, and to pay any other balance not paid for my insurance. **Self-pay patients must pay for their services in full on the day in which they are rendered.**

I understand that I am financially responsible for all charges incurred whether or not they are paid by my insurance.

I hereby authorize The Vine Medical Center to release information necessary to secure payment. Should the account be referred to a collection agency, the undersigned shall pay all reasonable attorney's fee and collection expenses.

Signature: _____ Date: _____

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NEW PATIENT MEDICAL HISTORY

NAME:	DATE OF BIRTH:

HOW DID YOU HEAR ABOUT US: _____

BRIEFLY STATE BELOW THE REASON FOR TODAY'S VISIT:

MEDICAL HISTORY

Medical Condition/Disease	Year Began	Medical Condition/Disease	Year Began

PAST SURGERIES/HOSPITALIZATIONS/SERIOUS INJURIES

SURGERY/HOSP/INJURY	MONTH/YEAR	SURGERY/HOSP/INJURY	MONTH/YEAR

ALLERGIES

MEDICATION OR FOOD	REACTION	MEDICATION OR FOOD	REACTION

SPECIALISTS YOU CURRENTLY SEE

NAME OF DOCTOR	SPECIALTY	REASON

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MEDICATIONS, VITAMINS, AND HERBAL SUPPLEMENTS

MEDICATION	STRENGTH	FREQUENCY	MEDICATION	STRENGTH	FREQUENCY
Example: Tylenol	500 MG	1-2 x Daily			

PLEASE TELL US THE MONTH AND YEAR OF YOUR LAST:

FLU VACCINE		STRESS TEST	
PNEUMONIA VACCINE		COLONOSCOPY	
SHINGLES VACCINE		BONE DENSITY	
TETANUS SHOT		ENDOSCOPY	
ROUTINE BLOOD LABS		ELECTROCARDIOGRAM(EKG)	
SUDO SCAN		EYE EXAM	
ANNUAL PHYSICAL			

WOMEN		**MEN**	
MAMMOGRAM		PROSTATE EXAM	
PAP SMEAR			

HAVE YOU BEEN EXPOSED TO ANY CHEMICALS OR NUCLEAR TOXINS?	**Y / N**

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SOCIAL & WORK HISTORY

HOW MANY CHILDREN DO YOU HAVE?_____AGES?_____

WORK STATUS: (CIRCLE ONE) EMPLOYED UNEMPLOYED RETIRED DISABLED

CURRENT OR PRIOR OCCUPATION: _____ HOURS WORKED PER WEEK: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

TYPE OF RESIDENCE YOU LIVE IN (HOUSE, ASSISTED LIVING, NURSING HOME):_____

SOME OF YOUR FAVORITE HOBBIES: _____

DO YOU EXERCISE? **Y / N** IF YES, WHAT KIND, DURATION, & FREQUENCY: _____

_____

DO YOU DRINK? **Y / N** TYPE OF ALCOHOL?_____ HOW OFTEN?_____

DO YOU SMOKE? **Y / N** PACKS PER DAY?_____ # OF YEARS SMOKED?_____

FORMER SMOKER? **Y / N** PACKS PER DAY?_____ WHAT YEAR DID YOU STOP?_____

HOW OFTEN DO YOU CONSUME CAFFEINE? (TEAS, SODAS, COFFEE)_____

ARE YOU SEXUALLY ACTIVE? **Y / N** DO YOU HAVE SEX WITH: **MEN** **WOMEN** **BOTH**

HOW MANY SEXUAL PARTNERS HAVE YOU HAD DURING THE PAST 12 MONTHS? _____

ARE YOU CONCERNED THAT YOU MAY HAVE BEEN EXPOSED TO HIV? _____

FAMILY HEALTH HISTORY PLEASE MARK ALL THAT APPLY TO YOU FAMILY'S HEALTH HISTORY

	FATHER	MOTHER	CHILDREN	SIBLINGS	GRANDPARENTS
HYPERTENSION	☐	☐	☐	☐	☐
HEART DISEASE	☐	☐	☐	☐	☐
STROKE	☐	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐	☐
AUTO IMMUNE DX	☐	☐	☐	☐	☐
DEMENTIA	☐	☐	☐	☐	☐
CANCER	☐	☐	☐	☐	☐
TYPE OF CANCER_____					
DEPRESSION	☐	☐	☐	☐	☐

HAS ANYONE IN YOUR FAMILY BEEN DIAGNOSED WITH HEART DISEASE BEFORE THE AGE OF 50? **Y / N**

CURRENT AND PAST MEDICAL CONDITIONS

SKIN	**RESPIRATORY/CARDIAC**	**MUSCULOSKELETAL**
□ RASHES	□ SHORTNESS OF BREATH	□ PAIN
□ ITCHING	□ COUGH	□ SWELLING
□ CHANGE IN HAIR OR NAILS	□ PRODUCTION OF PHLEGM	□ STIFFNESS
EYES	□ WHEEZING	□ DECREASED JOINT MOTION
□ GLASSES OR CONTACTS	□ COUGHING UP BLOOD	□ BROKEN BONE
□ CHANGE IN VISION	□ CHEST PAIN	□ SPRAINS
□ EYE PAIN	□ COPD	□ ARTHRITIS
□ DOUBLE VISION	□ NIGHT SWEATS	□ GOUT
□ FLASHING LIGHTS	□ FEVER	**NEUROLOGIC**
□ GLAUCOMA/CATARACTS	□ SWELLING IN HANDS/FEET	□ HEADACHES
EARS	□ BLUE FINGERS/TOES	□ SEIZURES
□ CHANGE IN HEARING	□ HIGH BLOOD PRESSURE	□ FAINTING
□ EAR PAIN	□ HEART SKIPPING BEATS	□ PARALYSIS
□ EAR DISCHARGE	□ HEART MURMUR	□ WEAKNESS
□ RINGING	□ HX OF HEART MEDICATION	□ LOSS OF MUSCLE SIZE
□ DIZZINESS	□ BRONCHITIS/EMPHYSEMA	□ MUSCLE SPASMS
NOSE/SINUSES	□ RHEUMATIC HEART DISEASE	□ TREMORS
□ NOSE BLEEDS	**GASTROINTESTINAL**	□ INVOLUNTARY MOVEMENT
□ NASAL STUFFINESS	□ CHANGE IN APPETITE OR WEIGHT	□ LOSS OF COORDINATION
□ FREQUENT COLDS	□ NAUSEA	□ NUMBNESS
ALLERGIES	□ HEARTBURN	□ TINGLING
□ HIVES	□ VOMITING	**ENDOCRINE**
□ SWELLING OF LIPS OR TONGUE	□ VOMITING BLOOD	□ ABNORMAL GROWTH HORMONE
□ HAY FEVER	□ CONSTIPATION	□ INCREASED URINE PRODUCTION
□ ASTHMA	□ DIARRHEA	□ THYROID PROBLEMS
□ ECZEMA/SENSITIVE SKIN	□ CHANGE IN BOWEL HABITS	□ HEAT/COLD INTOLERANCE
MOUTH/THROAT	□ ABDOMINAL PAIN	□ EXCESSIVE SWEATING
□ BLEEDING GUMS	□ EXCESSIVE BELCHING	□ DIABETES
□ SORE THROAT	□ EXCESSIVE FLATUS	**PSYCHIATRIC**
□ SORE TONGUE	□ FOOD INTOLERANCE	□ TENSION/ANXIETY
□ HOARSENESS	□ RECTAL BLEEDING/HEMMORRHOIDS	□ DEPRESSION/SUICIDAL
□ TROUBLE SWALLOWING	□ EXCESSIVE HUNGER/THIRST	□ MEMORY PROBLEMS
NECK	**URINARY**	□ UNUSUAL PROBLEMS_____
□ LUMPS	□ DIFFICULTY URINATING	□ SLEEP PROBLEMS
□ SWOLLEN GLANDS	□ PAINFUL/BURNING URINATION	□ PAST PSYCHIATRIC TREATMENT
□ GOITER	□ FREQUENT URINATION	□ CHANGE IN MOOD/CHANGE IN ATTITUDE TOWARDS OTHERS
□ STIFFNESS	□ URGENCY	**PERIPHERAL VASCULAR**
BREAST	□ INCONTINENCE OF URINE	□ BLOOD CLOTS
□ LUMPS	□ DRIBBLING	**MISC**
□ NIPPLE DISCHARGE	□ DECREASED URINE STREAM	□ EXPOSURE TO TB
HEMATOLOGIC	□ BLOOD IN URINE	□ EXPOSURE TO HIV
□ ANEMIA	□ UTI/STONES/PROSTATE INFECTION	
□ EASY BRUISING/BLEEDING	□ SEXUALLY TRANSMITTED DX	
□ BLOOD TRANSFUSIONS		

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PATIENT ALLERGY SCREENING

1. DO YOU HAVE SEVERE ASTHMA OR A HISTORY OF RESPIRATORY DISTRESS? **Y / N**
2. ARE YOU CURRENTLY TAKING BETA BLOCKERS? **Y / N / NOT SURE**
3. ARE YOU CURRENTLY PREGNANT? **Y / N**

1. HOW OFTEN DO YOU EXPERIENCE RUNNY NOSE, SNEEZING, OR STUFFED UP NOSE?
_____NEVER _____ SOMETIMES _____ OFTEN _____ ALWAYS

2. HOW OFTEN DO YOU EXPERIENCE ITCHY, WATERY, OR DRY EYES?
_____NEVER _____ SOMETIMES _____ OFTEN _____ ALWAYS

3. HOW OFTEN DO YOU EXPERIENCE HEADACHE OR SINS PAIN?
_____NEVER _____ SOMETIMES _____ OFTEN _____ ALWAYS

4. HOW OFTEN DO YOU EXPERIENCE POST-NASAL DRIP OR SORE THROAT?
_____NEVER _____ SOMETIMES _____ OFTEN _____ ALWAYS

5. HOW OFTEN DO YOU HAVE HIVES OR A RASH DUE TO ALLERGIES?
_____NEVER _____ SOMETIMES _____ OFTEN _____ ALWAYS

6. HOW OFTEN DO YOU WAKE UP AT NIGHT DUE TO ALLERGIES?
_____NEVER _____ SOMETIMES _____ OFTEN _____ ALWAYS

7. HOW OFTEN DO YOU GET TIRED BECAUSE OF YOUR ALLERGIES?
_____NEVER _____ SOMETIMES _____ OFTEN _____ ALWAYS

8. HOW OFTEN DO YOU MISS SCHOOL OR WORK BECAUSE OF YOUR ALLERGIES?
_____NEVER _____ SOMETIMES _____ OFTEN _____ ALWAYS

9. HOW OFTEN DO YOU LIMIT SOCIAL ACTIVITIES OR EXERCISE DUE TO ALLERGIES?
_____NEVER _____ SOMETIMES _____ OFTEN _____ ALWAYS

10. HOW LONG DO YOU HAVE TOTAL RELIEF FROM ALLERGY MEDICATIONS (OVER THE COUNTER OR PRESCRIPTION)?
_____ 8-24 HRS _____ 4-8 HRS _____ 1-3 HRS _____ NO RELIEF

11. HOW LONG HAVE YOU BEEN TAKING OVER THE COUNTER OR PRESCRIPTION ALLERGY MEDICATION?_____

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PATIENT NAME: _____ **D.O.B:** _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. **Little interest or pleasure in doing things:**
_____ Not at all _____ Several days _____ More than half the days _____ Nearly everyday

2. **Feeling down, depressed or hopeless:**
_____ Not at all _____ Several days _____ More than half the days _____ Nearly everyday

3. **Trouble falling or staying asleep, or sleeping too much:**
_____ Not at all _____ Several days _____ More than half the days _____ Nearly everyday

4. **Feeling tired or having little energy:**
_____ Not at all _____ Several days _____ More than half the days _____ Nearly everyday

5. **Poor appetite or overeating:**
_____ Not at all _____ Several days _____ More than half the days _____ Nearly everyday

6. **Feeling bad about yourself, that you are a failure or you have let yourself and your family down:**
_____ Not at all _____ Several days _____ More than half the days _____ Nearly everyday

7. **Trouble concentrating on things such as reading the paper or watching television:**
_____ Not at all _____ Several days _____ More than half the days _____ Nearly everyday

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:**
_____ Not at all _____ Several days _____ More than half the days _____ Nearly everyday

9. **Thoughts that you would be better off dead or hurting yourself in some way:**
_____ Not at all _____ Several days _____ More than half the days _____ Nearly everyday

If you checked off ANY problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

NOT DIFFICULT _____ SOMEWHAT DIFFICULT _____ VERY DIFFICULT _____EXTREMELY DIFFICULTY_____

FOR OFFICE CODING: NOT AT ALL = 0, SEVERAL DAYS = 1, MORE THAN HALF = 2, NEARLY EVERYDAY = 3

_____0_____+_____+_____+_____= _____

TOTAL SCORE = _____

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MEDICAL RECORDS RELEASE REQUEST

PATIENT NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____ CITY:_____ STATE: _____ ZIP:_____

SOCIAL SECURITY #:_____ PHONE #:_____

THE FOLLOWING FACILITY IS AUTHORIZED TO PROVIDE COPIES OF THE PATIENT'S IDENTIFIABLE HEALTH INFORMATION:

RELEASE FROM:

NAME:_____

ADDRESS:_____

PHONE #:_____ FAX #:_____

SEND TO:

NAME:_____

ADDRESS:_____

PHONE #:_____FAX #:_____

PURPOSE FOR RELEASING THE INFORMATION

□ MOVING AWAY FROM AREA □ TRANSFER OF CARE □ AT PATIENT'S REQUEST □ CONTINUATION OF CARE

INFORMATION TO BE RELEASED

□ OFFICE/TREATMENT NOTES □ LABS □ IMAGING (XRAY, CT, MRI) □ EKG □ OTHER_____

PLEASE INDICATE THE DATES OF SERVICE TO BE RELEASED

□ ENTIRE MEDICAL RECORDS FOR SERVICES RENDERED AT THIS OFFICE
□ LAST OFFICE NOTE, LABS, AND / OR X-RAY TEST RESULTS
□ OTHER (PLEASE SPECIFY) _____

I UNDERSTAND THAT IF MY RECORDS CONTAIN ANY DOCUMENTATION OF ALCOHOL ABUSE, PSYCHIATRIC CONDITION, DRUG ABUSE, OR COMMUNICABLE DISEASE, THIS INFORMATION WILL BE RELEASED AS PART OF MY RECORD.
I UNDERSTAND THAT IF THE PERSON OR FACILITY RECEIVING THIS INFORMATION IS NOT COVERED BY FEDERAL PRIVACY REGULATION, THIS INFORMATION WILL NO LONGER BE PROTECTED AND MAY BE RE-DISCLOSED.
I UNDERSTAND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION AND THAT MY REFUSAL TO SIGN WILL NOT AFFECT MY ABILITY TO OBTAIN TREATMENT.
I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, BUT REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED.
NOTE: THE REVOCATION MUST BE IN WRITING TO BE DELIVERED TO THE ABOVE ADDRESS OF THE PERSON / ENTITY OF WHOM WAS TO RELEASE INFORMATION.
I UNDERSTAND THAT UNLESS EARLIER REVOKED, THIS AUTHORIZATION WILL EXPIRE 30 DAYS AFTER THE DATE SIGNED.
I UNDERSTAND THAT THERE MAY BE A CHARGE FOR OBTAINING THE REQUESTED INFORMATION, RELATED CHARGES CAN BE OBTAINED BY CONTACTING THE MEDICAL RECORDS DEPARTMENT.
I UNDERSTAND THAT I HAVE THE RIGHT TO OBTAIN A COPY OF THIS AUTHORIZATION.

PATIENT SIGNATURE:_____DATE:_____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS / FAMILY MEMBERS

In accordance with Federal government privacy rule implemented through the Health Insurance Portability and Accountability Act of 1996 (HIPPA), in order for your healthcare provider or a staff member of The Vine Medical Center to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ I **DO NOT** authorize The Vine Medical Center to release any information concerning my medical care to any individual.

_____ I **DO** authorize The Vine Medical Center to verbally release any or all information concerning my medical care to the following individuals:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

PATIENT SIGNATURE: _____ DATE:_____

WITNESS SIGNATURE:_____ DATE: _____

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Controlled Medications

As of 03/01/2020, the Texas Prescription Monitoring Program requires physicians to check the DEA report on all patients taking controlled medications. To expedite the refill process in the room, please check the medications you are taking by placing a check mark beside the medications you currently take whether prescribed by one of our providers or another provider.

Thank you

Patient name: _____ Date of birth: _____

Group 1: Opioids

__ Tylenol 3
__ Tylenol 4
__ Codeine
__ Norco
__ Fentanyl
__ Morphine
__ Codeine
__ Oxycodone
__ Tramadol

Group 2: Benzodiazepines

__ Xanax
__ Klonopin
__ Valium
__ Lorazepam
__ Ativan
__ Restoril

Group 3: Barbiturates

__ Amytal
__ Fioricet

Group 4: Carisoprodol

__ Soma

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Mediation and Dispute Resolution Agreement

Your care is important to us, and we feel it is vital to your treatment that we communicate openly and honestly.
As such, we request that you: Ask questions and participate in your care, be honest about your history, symptoms, and other important health information, prepare for and keep scheduled visits, and be respectful to our office staff and healthcare providers.
In exchange, we agree that we will: Explain diagnosis, treatment recommendations, and outcomes in an easy-to-understand way, listen to your questions and help you make decisions about your care, keep discussions and records private, and determine when a referral or termination of care is appropriate.

MEDIATION: As a part of our emphasis on open communication, we ask our patients to sign this mediation agreement. While we do not anticipate any issues or concerns during the course of your treatment, if any arise, you (and/or your legal counsel) and your healthcare provider (and/or their legal counsel) agree to meet with a neutral mediator and work toward a solution. Whether or not a solution is found, mediation may postpone but does not remove or block your legal rights. Importantly, you agree that any usage or inference to a "claim" will be understood and read as "potential claim" until the mediation is complete. This designation allows us to begin in a less formal manner that has been shown to expedite the resolution process. Your signature on this page confirms that should a concern arise in any aspect of the care provided by this office, staff, and affiliated healthcare professionals, you agree to mediate first before pursuing legal action.

EXPERT WITNESSES: Further, if after mediation, you still wish to pursue a court action relating to your care, your signature on this page confirms that you will use, as your expert witness(es) in your legal action, American Board of Medical Specialties board-certified medical witness(es) in the same specialty as Physician. Furthermore, you agree that the physicians who you select will be in good standing and adhere to all of the rules and guidelines of professional conduct of the American Board of Medical Specialties. As consideration for this agreement, we agree that we will adhere to these same guidelines in selecting our expert witness(es) for any court action relating to your care.
I certify that I have read or had read to me the contents of this form. I understand the possible advantages that compliance with professional healthcare recommendations can provide as well as potential consequences of non-compliance. I attest that I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

_____ _____
Patient's or Patient Representative's Signature Date

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Patient Responsibility Agreement

At The Vine Medical Center, our providers believe that educating patients is an important part of prevention and treatment of medical conditions. Therefore, we want you to know your responsibilities as a patient. Following these points allows us to provide you with the best healthcare, and thus allows you to live your best quality of life:

- To the best of your ability, provide accurate information about your medical history
- Be knowledgeable about your healthcare plan
- Follow up on, and obtain copies of, all labs, procedures and diagnostic imaging results
- Make good-faith effort in keeping your appointments with all our providers

By signing below, you agree to all your responsibilities as a patient at The Vine Medical Center.

_____ _____

Patient Name Date of Birth

_____ _____

Signature of patient or representative Date