

**HUNTSVILLE PEDIATRIC AND ADULT MEDICINE ASSOCIATES**

**PATIENT INFORMATION**

Patient's Name \_\_\_\_\_ Sex  Male  Female Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-mail address \_\_\_\_\_

**Driver License #** \_\_\_\_\_ Marital Status  Single  Married  Widowed  
Occupation \_\_\_\_\_ Employer's Name \_\_\_\_\_ Work Phone \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Employer's Name \_\_\_\_\_ Work Phone \_\_\_\_\_  
**In case of emergency, notify** \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Phone \_\_\_\_\_  
Your Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_ Referred by \_\_\_\_\_

**Complete the Following if the Patient is a Minor or a College Student**

Responsible Party's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Father's Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
**Date of Birth** \_\_\_\_\_ **Driver License #** \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ OK to call  Yes  No  
Mother's Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
**Date of Birth** \_\_\_\_\_ **Driver License #** \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ OK to call  Yes  No  
Hospital where child was born \_\_\_\_\_  
Other Children (Names and Ages) \_\_\_\_\_  
Is there anyone other than a parent authorized to seek treatment for your child? If so, please list below:  
Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

**INSURANCE INFORMATION:** (Please provide copy of current insurance card)

Insurance Name \_\_\_\_\_ Policyholder's Name \_\_\_\_\_ **D.O.B.** \_\_\_\_\_  
Policy Number \_\_\_\_\_ Group # \_\_\_\_\_ Group Name \_\_\_\_\_  
Medicare # \_\_\_\_\_ Medicaid # \_\_\_\_\_

**RELEASE OF INFORMATION:**

I authorize Huntsville Pediatric and Adult Medicine Associates to release any medical or other information necessary to process claims for services provided to me.

**ASSIGNMENT OF BENEFITS:**

I authorize payment of government or other medical benefits to Huntsville Pediatric and Adult Medicine Associates for any services provided to me.

**FINANCIAL POLICY:**

I acknowledge that I have read and/or been offered a copy of this office's Financial Policy.

**PRIVACY POLICY ACKNOWLEDGEMENT:**

I acknowledge that I have read and/or been offered a copy of 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. I have read and agree to the Release of Information, Assignment of Benefits, Financial Policy, and Privacy Policy Acknowledgement paragraphs as stated above.

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Relationship to Patient If Not Parent or Legal Guardian

**HUNTSVILLE PEDIATIC AND ADULT MEDICINE ASSOCIATES**

**ADULT PAST MEDICAL HISTORY**

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Date: \_\_\_\_\_

**SURGERY (TYPE AND DATE)    HOSPITAL    SURGEON**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

**HOSPITALIZATIONS (TYPE AND DATE)    HOSPITAL    PHYSICIAN**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

**GYNECOLOGIC HISTORY:** Last Pap Smear \_\_\_\_\_ Last Mammogram \_\_\_\_\_  
First day of last menstrual period \_\_\_\_\_

**MEDICAL ILLNESSES:**

- 1. \_\_\_\_\_ 4. \_\_\_\_\_
- 2. \_\_\_\_\_ 5. \_\_\_\_\_
- 3. \_\_\_\_\_ 6. \_\_\_\_\_

**History of Blood Transfusions:** \_\_\_\_\_ **When:** \_\_\_\_\_

**IMMUNIZATIONS:**

**Last Tetanus Shot** \_\_\_\_\_ **Hepatitis B** \_\_\_\_\_

**Pneumovax** \_\_\_\_\_ **Flu Vaccine** \_\_\_\_\_

**Misc.** \_\_\_\_\_

**MEDICATIONS CURRENTLY TAKING (Prescription and Over The Counter)**

**Birth Control:** \_\_\_\_\_

**All Other:** \_\_\_\_\_

\_\_\_\_\_

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

**OTHER PHYSICIANS YOU USE FOR WHAT PROBLEM(S)?**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**FAMILY HISTORY:**

**FAMILY MEMBER**

**ACTIVE/DECEASED**

**ILLNESS/CAUSE OF DEATH**

**MOTHER** \_\_\_\_\_

**FATHER** \_\_\_\_\_

**BROTHER(S)** \_\_\_\_\_

**SISTER( S)** \_\_\_\_\_

**HAVE ANY FAMILY MEMBERS HAD: (Circle all that apply and explain in space below)**

**HEART ATTACK**

**OTHER HEART PROBLEMS**

**HYPERTENSION**

**HIGH CHOLESTEROL**

**STROKE**

**DIABETES**

**CANCER**

**TUBERCULOSIS**

**LUNG PROBLEMS**

**BLOOD DISEASE ( i.e. Sickle Cell or Leukemia)**

**DEPRESSION**

**SUICIDE**

**SEIZURES**

**ALCOHOLISM**

**Any other illnesses that run in the family?**

**EXPLANATION:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

PLACE OF BIRTH: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

OTHER COUNTRIES OR STATES LIVED IN: \_\_\_\_\_

WHO LIVES AT HOME WITH YOU: \_\_\_\_\_

EDUCATION: \_\_\_\_\_ Years HIGH SCHOOL: \_\_\_\_\_ Years COLLEGE: \_\_\_\_\_ Years

OCCUPATION: \_\_\_\_\_ SPOUSE'S OCCUPATION: \_\_\_\_\_

CHEMICAL EXPOSURES: \_\_\_\_\_

DO YOU SMOKE? \_\_\_\_\_ HOW MUCH DAILY? \_\_\_\_\_ FOR HOW LONG? \_\_\_\_\_

HOW MUCH ALCOHOL DO YOU DRINK? \_\_\_\_\_

DO YOU USE ANY OTHER TYPES OF DRUGS? \_\_\_\_\_

DO YOU EXERCISE REGULARLY? \_\_\_\_\_ IF YES, WHAT DO YOU DO? \_\_\_\_\_

DO YOU FOLLOW ANY PARTICULAR DIET? \_\_\_\_\_

DO YOU DRINK CAFFEINATED PRODUCTS? \_\_\_\_\_ HOW MANY PER DAY? \_\_\_\_\_

HOBBIES: \_\_\_\_\_

ANY CONCERNS: \_\_\_\_\_

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## History and Physical

Prier, David M.D. ( )  
Knight, John M.D. ( )  
McKeever, Gregory M.D. ( )  
Hsiao, Victor M.D. ( )  
Read, Glenda M.D. ( )  
Rollins, Lowell M.D. ( )  
Schulte, Jayne M.D. ( )  
Powell, Megan M.D. ( )  
Walkely, Candace M.D. ( )  
O'Brien, Patricia F.N.P. ( )  
Green, Jamie F.N.P ( )

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

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

Referred by: \_\_\_\_\_

DATE: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

History of Present Illness: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

Huntsville Pediatric and Adult Medicine Associates  
100 Medical Center Parkway, Suite 1000  
Huntsville, Texas 77340 Office: (936) 295-8000 Fax: (936) 439-1169

**Huntsville Pediatrics and Adult Medicine Associates**

**New Patient Review of Systems**

**Please check all that apply.**

PATIENT NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_  
\_\_\_\_\_ Stiffness \_\_\_\_\_ Blood in urine

**Health Survey for 65yrs. and older**

As your physician, I care about your well-being. During today's visit, you can use this handout as a guide to discuss your health concerns and needs. Please take a moment to answer these questions:

- Have you fallen or had trouble with balance or walking in the past 12 months?  
 Yes  No
- Do you have bladder controls problems?  
 Yes  No
- Does your physical health interfere with your daily activities?  
 Yes  No
- Would you best describe your emotional health as stable?  
 Yes  No

Provider Initials: \_\_\_\_\_

**General:**

- \_\_\_ Weight loss/gain
- \_\_\_ Fatigue or weakness
- \_\_\_ Fever or chills
- \_\_\_ Trouble sleeping

**Skin:**

- \_\_\_ Rashes
- \_\_\_ Lumps

**Head:**

- \_\_\_ Headache
- \_\_\_ Head injury
- \_\_\_ Neck pain

**Ears:**

- \_\_\_ Decreased hearing
- \_\_\_ Ringing
- \_\_\_ Earache or drainage

**Eyes:**

- \_\_\_ Vision loss/changes
- \_\_\_ Pain
- \_\_\_ Redness
- \_\_\_ Flashing lights
- \_\_\_ Glaucoma
- \_\_\_ Cataracts
- \_\_\_ Last eye exam: \_\_\_\_\_

**Nose:**

- \_\_\_ Stiffness
- \_\_\_ Discharge
- \_\_\_ Itching
- \_\_\_ Nosebleeds
- \_\_\_ Sinus pain

**Throat:**

- \_\_\_ Hoarseness
- \_\_\_ Sore
- \_\_\_ Thrush
- \_\_\_ History of sleep apnea

**Neck:**

- \_\_\_ Lumps
- \_\_\_ "Swollen glands"
- \_\_\_ Pain

**Breast:**

- \_\_\_ Lumps
- \_\_\_ Pain
- \_\_\_ Discharge
- \_\_\_ Breastfeeding
- \_\_\_ Last mammogram: \_\_\_\_\_

**Respiratory:**

- \_\_\_ Cough
- \_\_\_ Sputum production
- \_\_\_ Coughing up blood
- \_\_\_ Wheezing
- \_\_\_ History of Asthma/COPD
- \_\_\_ Painful breathing

**Cardiovascular:**

- \_\_\_ Chest pain or discomfort
- \_\_\_ Tightness
- \_\_\_ Palpitations
- \_\_\_ Shortness of breath (SOB) with activity
- \_\_\_ Difficulty breathing lying down
- \_\_\_ Difficulty with usual activities due to lack of energy
- \_\_\_ Leg swelling
- \_\_\_ Sudden awaking from sleep with SOB

**Gastrointestinal:**

- \_\_\_ Swallowing difficulties
- \_\_\_ Heartburn
- \_\_\_ Change in appetite
- \_\_\_ Nausea or vomiting
- \_\_\_ Rectal bleeding
- \_\_\_ Constipation or diarrhea
- \_\_\_ Yellow eyes or skin
- \_\_\_ Last colonoscopy: \_\_\_\_\_

**Urinary:**

- \_\_\_ Frequency
- \_\_\_ Urgency
- \_\_\_ Burning or pain

- \_\_\_ Bladder leakage
- \_\_\_ Urinary incontinence
- \_\_\_ Change in urinary strength

**Vascular:**

- \_\_\_ Calf pain with walking
- \_\_\_ Leg cramp

**Musculoskeletal:**

- \_\_\_ Muscle or joint pain
- \_\_\_ Stiffness
- \_\_\_ Back pain
- \_\_\_ Joint redness
- \_\_\_ Joint swelling

**Neurologic:**

- \_\_\_ Dizziness
- \_\_\_ Fainting
- \_\_\_ Seizures
- \_\_\_ Headaches
- \_\_\_ Numbness
- \_\_\_ Weakness
- \_\_\_ Tingling
- \_\_\_ Tremor

**Hematologic:**

- \_\_\_ Easy bruising
- \_\_\_ Easy bleeding

**Endocrine:**

- \_\_\_ Heat or cold intolerance
- \_\_\_ Sweating excessively
- \_\_\_ Urinating at night > once
- \_\_\_ Change in appetite
- \_\_\_ Abnormal menstrual cycles
- \_\_\_ Menopause symptoms
- \_\_\_ Hysterectomy
- \_\_\_ Last pap smear: \_\_\_\_\_

**Psychiatric:**

- \_\_\_ Nervousness
- \_\_\_ Stress
- \_\_\_ Depression
- \_\_\_ Memory problems
- \_\_\_ History of physical or sexual abuse

Name: \_\_\_\_\_ Date: \_\_\_\_\_

## PHYSICAL EXAMINATION

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ T: \_\_\_\_\_ P: \_\_\_\_\_ R: \_\_\_\_\_ BP: \_\_\_\_\_  
BMI: \_\_\_\_\_ Nurse/MA \_\_\_\_\_

General Appearance: \_\_\_\_\_

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**Skin:**

**HEENT:**

**Lymph Nodes:**

**Neck:**

**Breasts:**

**Lungs:**

**Heart:**

**Pulse:** Radial Brachial Carotid Femoral Popliteal PT DP

**R:**

**L:**

**Burits:**

**Abdomen:**

**Rectal:**

**Pelvic:** Ext

**GU:** Penis

Vag

Testes

CX

UT/AD

**Extremities:**

**Neuro:**

\_\_\_\_\_  
M.D.



Acknowledgement of Financial Policy

- I understand Huntsville Pediatric and Adult Medicine Associates (HPAM) will copy my insurance card and driver’s license. I further understand it is my responsibility to notify HPAM in the event of insurance coverage change.
- I understand HPAM will obtain demographic information including mailing address, contact phone numbers, and email address. In addition, I understand HPAM may use and disclose demographic and medical information in order to provide a written, telephone, text message, or email reminder of an upcoming appointment. I further understand it is my responsibility to notify HPAM if any demographic information changes.
- I understand HPAM does not accept Worker’s Comp.
- I understand payment for co-payments, deductibles, and percentages not covered by insurance are due from me at the time services are rendered. In addition, I understand the amount collected is only an estimate and the amount due may increase due to accounting error, insurance company payments and/or correspondence and additional services provided during and/or after visits including additional lab.
- I understand if I do not have insurance coverage I will be responsible for services rendered at the time of service and any additional services provided after my visit including additional lab services.
- If I am a Medicare recipient, I understand I will be responsible for annual deductibles, 20% co-insurance, non-covered services, and any charges Medicare states I am responsible for.
- I understand a \$30.00 service charge will be applied to all returned checks.
- I understand a \$25.00 fee will be charged for missed appointments and for appointments cancelled less than 4 business hours prior to my appointment time.
- I understand I will receive a separate statement from the Radiologist that interprets all x-rays done at HPAM.
- I understand that a fee is charged for copies of medical records and is due prior to the release of records.

**For Insurance Billing:**

**I hereby authorize Huntsville Pediatric and Adult Medicine Associates (HPAM) to furnish my insurance company with all the information which the insurance company may request concerning me and/or my present illness or injury. I hereby assign to Huntsville Pediatric and Adult Medicine Associates all money to which I am entitled for medical expenses related to the service reported. I understand I am financially responsible to Huntsville Pediatric and Adult Medicine Associates for charges not covered by this assignment.**

**Patient Name:** \_\_\_\_\_ **Patient DOB:** \_\_\_\_\_

**Responsible Party:** \_\_\_\_\_ **Responsibly Party:** \_\_\_\_\_  
Printed Name Signature

**Date:** \_\_\_\_\_



*Huntsville Pediatric & Adult Medicine*  
A S S O C I A T E S

**Patient Authorization to Release Protected Health Information**

I, \_\_\_\_\_, give my authorization to release my protected information including results of my laboratory tests, x-ray, and/ or other test results to the following designated representative(s).

\_\_\_\_\_ (Initial) Spouse Name \_\_\_\_\_

\_\_\_\_\_ (Initial) Child(ren) Name(s) \_\_\_\_\_

\_\_\_\_\_ (Initial) Other Name(s) \_\_\_\_\_

\_\_\_\_\_ (Initial) Parent Name(s) \_\_\_\_\_

\_\_\_\_\_ (Initial) Authorize Huntsville Pediatric and Adult Medicine to call the following numbers and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care such as test results.

\_\_\_\_\_ (Initial) Home Number (as on file)

\_\_\_\_\_ (Initial) Cell Number (as on file)

\_\_\_\_\_ (Initial) Work Number (as on file)

\_\_\_\_\_ (Initial) Other Number(s): \_\_\_\_\_

\_\_\_\_\_ (Initial) Authorize Huntsville Pediatric and Adult Medicine to mail to the following address any items that assist the practice in carrying out treatment, payment. And healthcare operations, such as appointment reminder cards, unable to reach patient by phone letters, and statements as they are marked Personal and Confidential.

\_\_\_\_\_ (Initial) My home address (as on file).

\_\_\_\_\_ (Initial) Other address: \_\_\_\_\_

I understand that this release of information is considered valid until a new release of information is submitted or my child turns 18. The office will not disclose any information to any items above that do not have an initial beside it.

Patient or Legal Guardian Signature: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Date: \_\_\_\_\_

.....  
**Office Use Only:**

\_\_\_\_\_ This patient is a child and will be 18 as of \_\_\_\_/\_\_\_\_/\_\_\_\_ and will need a new release of information form.

*Huntsville Pediatric & Adult Medicine*  
A S S O C I A T E S

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Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_  
Billing Address \_\_\_\_\_ City \_\_\_\_\_  
Zip Code \_\_\_\_\_ Primary Contact Number \_\_\_\_\_

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**2019**

**COORDINATION OF BENEFITS**

My primary insurance coverage: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Do you have other health coverage? Please check one:**

No, the above insurance is the only active insurance, go to signature section.

No Insurance/Private Pay

Yes, please give name of Other Insurance Carrier below, sign, and date.

**OTHER INSURANCE CARRIER:**

Name of the Other Insurance Carrier: \_\_\_\_\_

Name of the Subscriber for the Other Insurance policy: \_\_\_\_\_

Name of the Employer: \_\_\_\_\_

Insurance Carrier Claim address: \_\_\_\_\_

Insurance Carrier phone number: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Beginning date of Coverage: \_\_\_\_\_ End date of Coverage (if applicable): \_\_\_\_\_

Other insurance covers?  Self  Spouse  Child  Other \_\_\_\_\_

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**Signature (Parent/Guardian, if minor)/Relationship to Patient**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_