Welcome

THANK YOU FOR CHOOSING A PREMIER PRACTICE.

We look forward to providing you with professional health care in a friendly and welcoming environment. To best partner with you in your care, we have outlined expectations below which will promote an ideal provider-patient relationship.

WE PROMISE TO:

- Treat patients with respect and dignity
- Learn about the person as well as the condition.
- Partner with our patients in medical decision making.
- Engage, listen, and clearly explain issues to our patients.
- Strive to make each patient feel like they are our priority.
- Return calls and messages promptly.
- Be timely and respect our patients' time as much as our own.
- Thank patients for waiting when we are behind schedule.
- Respect patient privacy.
- Earn patient's loyalty through our actions.

WE ASK OUR PATIENTS:

- Treat others with courtesy, respect, and dignity.
- Be patient and understanding.
- Tell our office about any changes in your contact information, health issues, medications, other healthcare providers, insurance, and employment.
- To arrive on time for scheduled appointments.
- Call the office if you cannot make an appointment or are running late.
- Provide payment for services provided.
- Follow your treatment plan and inform your care team of any changes
- Ask questions if directions or procedures are not clear.

Our Locations

Aubrey
972-347-2777
Fax 972-347-2776

Boyd
940-433-2151
Fax 940-433-2366

Bridgeport
940-683-2338
Fax 940-683-2394

Decatur
940-627-7440
Fax 940-539-4035

Denton
940-566-5010
Fax 940-382-0980

Gainesville
940-580-3070
Fax 940-580-2042

Grand Prairie
972-266-5354
Fax 972-266-7876

McKinney
214-491-5606
Fax 972-746-4778

Pilot Point
940-686-2254
Fax 940-686-2830

Sanger
940-458-4774
Fax 940-458-0212

White Rock
214-328-3610
Fax 214-328-3620

PREMIER
Independent Physicians

NEW PATIENT FORM

PATIENT DEMOGRAPHICS & INSURANCE

Patient Last Name | First Name | MI | Preferred Name

Mailing Address | City | State | Zip

Home Phone ☐ *Primary Number* | Work Phone ☐ *Primary Number* | Mobile Phone ☐ *Primary Number*

Email Address

Emergency Contact Full Name & Relationship | Primary Phone | Secondary Phone

I authorize detailed messages containing medical information about me and my care in a voicemail at the following numbers:

☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ Emergency Primary ☐ Emergency Secondary

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Sex

☐ Male ☐ Female

Date of Birth

Race

☐ American Indian or Alaska Native ☐ Asian ☐ White ☐ Other

☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander

Ethnicity

☐ Hispanic or Latino

☐ Not Hispanic or Latino

☐ Unknown

Pharmacy Name | Pharmacy Address | Pharmacy Phone

INSURANCE & SUBSCRIBER INFORMATION

Primary

Insurance Company

Name of Primary Subscriber

Member ID/Policy No.

Group No.

Secondary

Insurance Company

Name of Primary Subscriber

Member ID/Policy No.

Group No.

IMPORTANT NOTICE - CANCELLATION, NO SHOW, & LATE ARRIVALS

If you cancel an appointment with less than 24 hours' notice or do not arrive for a scheduled appointment, you will be charged a **$35.00** fee for the missed appointment.

If you arrive **15 minutes or later** to your scheduled appointment, you may be asked to rescheduled your appointment.

ACKNOWLEDGMENT OF POLICIES

Please initial your acknowledgment of each policy and sign at the bottom of the page.

_____ **Financial Acknowledgment**
I have read and understand the Patient Financial policy, and I agree to its terms. I also understand and agree that the Company may amend such terms from time to time.

_____ **Privacy Practices Notice**
Premier Independent Physicians and its affiliated practices reserve the right to modify the Privacy Practices outlined in the notice. I have reviewed or have been given the opportunity to review Premier'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 the Notice of Privacy Practices. If you would like to receive a copy of our Notice of Privacy Practices, please request a copy from a staff member or visit our website at www.piptx.com.

_____ **I have read and understand the Cancellation, No Show, and Late Arrival policy.**

_____ **I have read and understand the Text and Email Communication policy.**

_____ **I have read and understand the Patient Portal policy.**

RELEASE YOUR PROTECTED HEALTH INFORMATION - INDIVIDUALS

Name/Relationship	Phone Number	Information Authorized
		☐ All ☐ Scheduling ☐ Medical ☐ Billing
		☐ All ☐ Scheduling ☐ Medical ☐ Billing
		☐ All ☐ Scheduling ☐ Medical ☐ Billing

I have reviewed the above information and authorize my protected health information to be released to the individuals listed, as specified. I understand this authorization applies to both written and verbal communications. I also understand that I may request to revoke this authorization, in writing, at any time.

CONSENT TO TREAT

I hereby authorize employees and agents of Premier Independent Physicians and its affiliated practices (including physicians, advanced practitioners, and other employees and staff members) to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

Patient Name (please print)

Signature of Patient, Parent, or Legal Guardian **Date**

Complete this section ONLY if the patient is a minor

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical treatment, surgical procedures, and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

Signature of Parent or Legal Guardian **Date**

PRESCRIPTION POLICY

Premier Independent Physicians and its affiliated practices are medical offices that provide treatment for various types of conditions. In some cases, patients may be prescribed medication to treat their pain. Correct usage of these medications can greatly improve patients' quality of life; however, it is important to note that these medications can also be misused. As a result, both the State of Texas and the Federal Drug Enforcement Administration regulate their use. Premier's practices follow those laws and have adopted the following policy:

Our Policy

- Please allow 72 business hours for prescription request processing.
- Requests to transfer ADD/ADHD medications to a different pharmacy after the prescription is sent will incur a $10 fee per prescription.
- Written prescriptions will not be replaced if lost, stolen, destroyed, or misplaced.
- Prescriptions are to be taken as directed. Do not change the frequency of the dose unless otherwise directed by your provider. If a change does occur, this will be documented in your chart.
- By law, controlled substances cannot be refilled over the phone.
- Refills for prescriptions listed below may be refilled every three months. As a result, if you were not seen in our office in the last three months, prescriptions for the following medications cannot be refilled. Exceptions to this must be discussed with your provider during an office visit. Exceptions will not be granted over the phone.
  a. Sleep Aids such as Ambien or Lunesta
  b. Anti-inflammatories such as Celebrex, Ibuprofen, or Naproxen
  c. Narcotics such as Lortab, Vicodin, Darvocet, or Hydrocodone
  d. Muscle Relaxers such as Soma, Flexeril, or Robaxin.
- If your prescription bottle indicates that you have refills remaining, contact your pharmacy directly. If there are no refills left, contact our office and schedule an appointment.
- Refills will not be authorized at night, on weekends, or on holidays. Please plan ahead to be sure you have enough medication.
- Before you visit our practice, please check your supply of medication. If you need refills, please ask for them during your appointment.
- Refill requests for hormone replacement and birth control pills can only be refilled if you have a routine gynecology appointment scheduled. Exceptions to this must be discussed with your provider during an office visit. Exceptions will not be granted over the phone.
- Refill requests for prescriptions not prescribed by your provider will not be authorized.
- Please do not contact the office more than once about a medication or refill. Your provider is the only person who can approve your medication to be refilled.

I have read the above prescription policy and I am aware of the necessary steps in order to have prescriptions refilled. I agree to this policy and understand that this signed policy will be scanned into my chart. I understand that if I do not adhere to this policy or do not use my prescribed medications as directed or overuse my prescribed medications, Premier Independent Physicians and my health care provider may terminate the provider-patient relationship.

Patient Name (please print) **Date of Birth**

Signature of Patient, Parent, or Legal Guardian **Date**

RELEASE YOUR PROTECTED HEALTH INFORMATION - PROVIDERS

This is a release form for permission for your medical information to be used and/or disclosed between healthcare providers, insurance companies, and any other party involved in your medical care.

I, _____ Date of Birth _____, hereby authorize the

Providers listed below to release all medical information to:
Premier Independent Physicians and its affiliated practices.

This request includes hospital summaries, laboratory reports, physician progress notes, and any other healthcare information related to my condition.

Please list the names and fax numbers of the providers/doctors you see so they may share your records with us.

Provider/Doctor Name	Fax Number

I hereby authorize the above-mentioned provider/facility to release and/or disclose the medication information as indicated below to: Premier Independent Physicians and its affiliated practices. I also understand this information may contain information related to Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV), mental health conditions/diagnosis, and alcohol and/or substance abuse.

Effective Time Period: This authorization is valid until the death of the individual, the individual reaching the age of majority, permission is withdrawn, or the following specific date: _____

Right to Revoke: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to Premier Independent Physicians and its affiliated practices. I understand that prior actions taken in reliance on this authorization will not be affected.

Redisclosure: I understand that Premier Independent Physicians and its affiliated practices may not lawfully further use or disclose the health information unless authorization is obtained from me or unless disclosure is specifically required or permitted by law.

Please specify records to be released and/or disclosed.

☐ Entire Medical Record ☐ History and Physical ☐ Chart Summary ☐ Labs ☐ Radiology ☐ Pathology
☐ Other (please specify)

Your initials are required to release the following information.

_____ Mental Health Records (excluding psychotherapy notes) _____ Genetic Information (including testing results)
_____ Drug, Alcohol, or Substance Abuse Records _____ HIV/AIDS Test Results and/or Treatment

I request that the health information release and/or disclosed pursuant to this authorization be used for the following purpose only:

☐ Physician/Healthcare Facility ☐ Legal ☐ Personal ☐ Other

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization. I understand that there may be a fee for preparing and furnishing my health information.

Patient Name (please print)

Signature of Patient, Parent, or Legal Guardian **Date**

Patient Name:

MEDICAL HISTORY

What is the reason for your visit today and when did your problem symptoms begin?

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Yes	No	Condition
		Acid Reflux			Hepatitis B
		Alcoholism			Hepatitis C
		Allergy Problems			Hernia
		Anemia			High Blood Pressure
		Anxiety			High Cholesterol
		Artery/Vein Problems			Human Immunodeficiency Virus (HIV)
		Arthritis			Irregular Heart Rhythms
		Asthma			Irritable Bowel
		Autoimmune Disease			Kidney Disease
		Bipolar Disorder			Liver Disease
		Bladder Irritability			Lung Disease
		Bleeding Problems			Mental Illness
		Blood Clots			Migraines
		Cancer			(MRSA)
		Cataracts			Osteoporosis
		Chronic Pain			Post-Traumatic Stress Disorder
		Colitis/Crohn's			Recurrent Skin Infections
		Depression			Recurrent Urinary Tract Infections
		Diabetes			Schizophrenia
		Esophagitis, Ulcers			Seizures
		Fractures			Sleep Apnea
		Gallstones			Sexually Transmitted Infections (STIs)
		Glaucoma			Stroke
		Gout			Substance Abuse
		Headaches			Suicide Attempts
		Hearing Impairment			Suicidal Thoughts
		Heart Attack			Tuberculosis
		Heart Disease			Thyroid Disease
		Heart Valve Problems			Vision Impairment
		Hepatitis A			Other

SURGICAL HISTORY (LIST THE MOST RECENT DATE FOR ANY SURGERIES/EXAMS OF THE FOLLOWING)

Appendectomy		Coronary Artery Bypass Graft	
Back Surgery		Hysterectomy	
Cardiac Catheterization		Implantable Defibrillator	
Cardiac Stent		Inguinal Hernia Repair	
Carotid Endarterectomy		Mastectomy	
Cataract Surgery		Permanent Pacemaker	
Cesarean Section		Tonsillectomy	
Cholecystectomy		Other:_____	

Patient Name:

FAMILY HISTORY

Please list the blood relatives who have been diagnosed with the following conditions:

Condition	Mother	Father	Grandmother	Grandfather	Brother	Sister	Other:	Other:
Acid Reflux								
Alcoholism								
Allergy Problems								
Anemia								
Anxiety								
Artery/Vein Problems								
Arthritis								
Asthma								
Autoimmune Disease								
Bipolar Disorder								
Bladder Irritability								
Bleeding Problems								
Blood Clots								
Cancer								
Cataracts								
Chronic Pain								
Colitis/Crohn's								
Depression								
Diabetes								
Esophagitis, Ulcers								
Fractures								
Gallstones								
Glaucoma								
Gout								
Headaches								
Hearing Impairment								
Heart Attack								
Heart Disease								
Heart Valve Problems								
Hepatitis A								

Condition	Mother	Father	Grandmother	Grandfather	Brother	Sister	Other:	Other:
Hepatitis B								
Hepatitis C								
Hernia								
High Blood Pressure								
High Cholesterol								
Human Immunodeficiency Virus (HIV)								
Irregular Heart Rhythms								
Irritable Bowel								
Kidney Disease								
Liver Disease								
Lung Disease								
Mental Illness								
Migraines								
Methicillin-resistant Staphylococcus aureus (MRSA)								
Osteoporosis								
Post-Traumatic Stress Disorder								
Recurrent Skin Infections								
Recurrent Urinary Tract Infections								
Schizophrenia								
Seizures								
Sleep Apnea								
Sexually Transmitted Infections (STIs)								
Stroke								
Substance Abuse								
Suicide Attempts								
Suicidal Thoughts								
Tuberculosis								
Thyroid Disease								
Vision Impairment								
Other								

Is your mother living? ☐ Yes ☐ No If not, what was the cause of death? _____

Is your father living? ☐ Yes ☐ No If not, what was the cause of death? _____

Is there anything else about your or your family's medical history we should know?

_____

_____

_____

Patient Name:

SMOKING STATUS

Check One	
	Current every day smoker (an individual who has smoked at least 100 cigarettes during his/her lifetime and still regularly smokes every day)
	Current every day smoker (an individual who has smoked at least 100 cigarettes during his/her lifetime and still regularly smokes periodically, yet consistently)
	Former smoker (an individual who has smoked at least 100 cigarettes during his/her lifetime but does not currently smoke)
	Never smoker (an individual who has not smoked at least 100 cigarettes during his/her lifetime)
	Smoker, current status unknown (an individual who has smoked at least 100 cigarettes during his/her lifetime, but whether they currently still smoke is unknown)
	Unknown if ever smoked (unknown if an individual has ever smoked)
	Heavy tobacco smoker (an individual who smokes more than 10 cigarettes per day, or an equivalent quantity of cigar or pipe smoke)
	Light tobacco smoker (an individual who smokes less than 10 cigarettes per day, or an equivalent quantity of cigar or pipe smoke)

SOCIAL HISTORY

Alcohol

☐ Social alcohol use ☐ Denies alcohol use ☐ Drinks alcohol regularly ☐ Occasional alcohol use

Diet

☐ ADA ☐ Low Calorie ☐ Low Salt ☐ High Protein

☐ Low Fat ☐ Regular

Illicit Drugs

☐ Caffeine ☐ Marijuana ☐ Oxycodone ☐ Cocaine

☐ No history of illicit drug use

Marital Status

☐ Has children ☐ Widowed ☐ Lives with partner ☐ Single

☐ Divorced ☐ Lives w/roommate ☐ Married

Working Status

☐ Currently working ☐ Homemaker ☐ Retired ☐ Works part time

☐ Full time student ☐ Part time student ☐ Unemployed

ALLERGIES

☐ **No known allergies**

Please include medication, food, latex, and environmental allergies):

Allergy to:			
Severity:	☐ Mild ☐ Moderate ☐ Severe	☐ Mild ☐ Moderate ☐ Severe	☐ Mild ☐ Moderate ☐ Severe
Reaction:			

Patient Name:

CURRENT MEDICATIONS

LIST ANY MEDICATIONS INCLUDING NON-PRESCRIPTION, VITAMINS, AND SUPPLEMENTS. PLEASE INCLUDE THE DRUG NAME, DOSE, HOW MANY TIMES PER DAY, & HOW LONG YOU HAVE BEEN TAKING THE MEDICATION)

1		5		9	
2		6		10	
3		7		11	
4		8		12	

HEALTH MAINTENANCE

(LIST THE MOST RECENT DATE FOR EACH OF THE FOLLOWING)

WOMEN ONLY		BOTH MEN AND WOMEN		MEN ONLY	
Menstrual period		Cholesterol testing		Digital rectal exam	
Mammogram		Colonoscopy/ Cologuard		PSA (prostate blood test)	
Pap Smear		Bone Density (DEXA)			

IMMUNIZATIONS

(LIST THE MOST RECENT DATE FOR EACH OF THE FOLLOWING)

(PLEASE PROVIDE CURRENT IMMUNIZATION RECORDS FOR MINORS)

Tetanus vaccination		Hepatitis B vaccination	
Flu vaccination		COVID vaccination	
Pneumonia vaccination		Shingles vaccination	

PAST PHYSICIANS AND HOSPITALIZATIONS

Doctor/Clinic Name	Length of Treatment	Location (City/State)	Reason for Treatment

Have you ever been hospitalized?

☐ No ☐ Yes (*If yes, please provide information below.)*

Doctor/Clinic Name	Dates of Stay	Location (City/State)	Reason for Treatment