Porter Medical Associates

REGISTRATION FORM

Please fill out as completely and clearly as possible

Date:_____ **Who may we thank for the referral to us?**_____

Mr.|Mrs.|Ms. _____ _____ _____ **Gender**: M F **Date of Birth**: _____/_____/_____
circle First Name MI Last Name circle MM DD YYYY

Social Security Number:_____-_____-_____ **Primary Language:** English Spanish Other:_____

Race: White Black Asian Native American Alaskan/Aleutian **Ethnicity**: Hispanic Non-Hispanic

Circle one: Married Single Divorced Domestic Partner Widowed Legally Separated

Home Phone: _____-_____-_____ **Cell Phone**: _____-_____-_____ **Work Phone**: _____-_____-_____

Email*:_____
(*email is required for correspondence through our health information portal; we do not send spam or advertisements)

Mailing Address: _____ **City, State, Zip:** _____
Spouse/Sig. Other Name: _____ **Spouse Contact Number**:_____-_____-_____
Emergency Contact:
Name:_____**Relationship:** _____**Phone#**:_____-_____-_____

INSURANCE INFORMATION

Please present your card(s) at every visit to ensure proper assignment of your benefits

Primary Insurance Name: _____ **ID#** _____

Policy holder's Name: _____ **Policy holder's DOB:** _____

Policy holder's SS#: _____ **Policyholder's Employer:** _____

Secondary Insurance Name:_____ **ID#**_____

Secondary Policy holder's Name: _____ **Secondary Policy holder's DOB:** _____

Secondary Policy holder's SS#: _____ **Secondary Policy holder's Employer:** _____

I hereby assign all medical and/or in-office surgical/procedure benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to Porter Medical Associates, PA. This assignment is valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all information to secure payment.

Patient Signature:_____ **Date**:_____

2829 Babcock Rd | Suite 117 | San Antonio, Texas | 78229 | Ph. 210-341-9614 | Fax. 210-340-5924
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2020 Sundance Pkwy| Suite A2| New Braunfels, Texas | 78130 | Ph. 830-387-2110 | Fax. 830-609-9918

Patient Name:_____
Patient DOB:_____

Porter Medical Associates

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Please fill out as completely and clearly as possible

Are you here today due to an injury from a motor vehicle accident or work-related injury? □Yes* □No
* If you answered yes, please see the receptionist before continuing to complete this form.

Do you have or have had any of the following? (check the box if the diagnosis applies to you)
□Diabetes □Seizures □Multiple Sclerosis □Parkinson's Disease □Restless Leg Syndrome □Hypertension □Headaches
□Neuropathy □Alzheimer's Disease □Arthritis □High Cholesterol □Cancer,type:_____
□Broken Bones:_____ □Other_____

Have you ever been hospitalized in the past?□No □Yes If yes, please complete the following:
□Surgery,Reason(s):_____ □ Other Medical Condition(s):_____
□ Childbirth ----> Natural □ C-Section □

Have you ever used tobacco in any form? □No □Yes Cigarettes□ Snuff/Skoal-type□ Chewing Type □ Pipe□ Cigar□
Other□_____ When did you start using?_____
How much do/did you use daily?_____ If you have since quit, when did you quit?_____

Have you ever used recreational drugs in any form? □No □Yes
□Marijuana□ LSD□ Pills□(type_____) Cocaine□ Heroin□ Meth□ Other□_____
When did you start using?_____ How much do/did you use daily?_____
If you have since quit, when did you quit?_____

Have you ever used alcohol in any form? □No □Yes: Wine □ Beer □ Liquor □
When did you start drinking?_____ How much do/did you drink daily?_____
If you have since quit, when did you quit?_____

Do you have any allergies?_____**Would you like allergy testing?**: □No□Yes
□Medications _____ □Foods_____
□Environmental(cats, pollen, trees, etc) _____
If there are things that you are intolerant to, but do not have a true allergy, please list them here:
(for example, some medications give certain people muscle aches, or stomach upset)

_____

Please list your medications, vitamins, and supplements: Medication Name: How do you take this: Written by (PCP or Other)

_____ _____ _____
_____ _____ _____

What pharmacy do you use: _____ **Pharmacy Address:** _____

Do you have an Advanced Directive?□No □Yes **Does your Advanced Directive indicate 'Do Not Resuscitate?**□No □Yes
Do you have a Durable Power of Attorney?□No □Yes If yes, please provide a copy at your earliest convenience.

Do you have a family history of chronic diseases or premature death? □No □Yes If yes, please describe:

_____

Is there anything else you'd like the doctor to know about your medical history, social history or general condition that may help him deliver better care to you?_____

_____

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Patient Name:_____
Patient DOB:_____

Porter Medical Associates

REGISTRATION FORM

Please fill out as completely and clearly as possible

Main Office Hours
Monday & Wednesday 7:30 AM - 4:30 PM
Tuesday & Thursday 8:00 AM - 5 PM
Friday's 7:30 AM - 12 NOON

We are glad you have chosen us to provide you with your medical needs. We have adopted the following policies, if you have any questions please discuss them with the office manager. We are dedicated to providing the best possible care for you and your family.

1. **APPOINTMENTS** - This office is an appointment only office. You need to schedule an appointment in order to see the physician. If you arrive earlier you will only be seen sooner if there is an opening. **NO WALK INS ALLOWED.**
NEW PATIENTS-Confirmation is required no later than 24 hours before the appointment to avoid cancellation.
2. **PAYMET FOR SERVICE** - Unless other arrangements have been made in advance, we require payment at the time of service. We accept cash, checks,Visa, Master card and Care Credit ONLY!
3. **INSURANCE** - We have made prior arrangements with many health plans to accept an assignment of benefits. This means we will bill those plans with which we are contracted.
4. **THIRD PARTY INS**. - We do not accept third party insurance (i.e. automobile insurance- if involved in an auto accident, or Letter of Protection- payment directly from a law office). If you are involved in any of these cases, you will be required to pay the office visit in full, and be reimbursed by your third party.
5. **MINORS** - All minors must be accompanied by an adult over 18 years old. For all services rendered to minor patients, the adult accompanying the patient will be held responsible for payment, unless prior arrangements have been made.
6. **NO-SHOWS** - In order to ensure that all appointments available are being used, we do charge a **$50.00** fee for **"NO SHOWS"** and/or APPOINTMENTS that are NOT canceled 24 HOURS prior to the scheduled appointment time. Acquiring (3) NO SHOWS may result in termination from the practice.
7. **PRESCRIPTIONS** - If you require a refill on your medications, please call your pharmacy, they will contact us. The providers write your prescriptions with enough refills to last until you are due for follow up. If you are out of refills, you may be due for a follow up. The only exception is if you require a triplicate prescription. All controlled medications require a current Toxicology Screen. Please allow 48-72 hours for refills so we may review your chart. **PAPER PRESCRIPTIONS** - will only be written if required by the DEA. Otherwise, there will be a $5 charge if not necessary.
8. **REFERRALS** - All HMOs require a referral by your PCP, if you need to see a specialist. Please allow up to 72 hours, depending on your insurance plan, to process the referral.
9. **FMLA** - Family Leave and Disability Forms, Sports/Work Physical Forms and/or any professional Letters, will require a $40.00 administration fee, and is paid up front. These are not covered by your insurance company. Please allow 7-10 business days for completion after your payment.
10. **MEDICAL RECORDS** - If you would like copies of your medical records there is a $25.00 fee for the 1st 20 pages, and $0.50 for each additional page. As a courtesy, there is no charge for transferring your medical records directly another to physician's office for continuity of care.
11. **AFTER HOUR CARE** - If you require medical care after office hours, simply call our office and you will be forwarded to an answering service. Depending on the situation, the Dr. will be paged. You will always have access to your Doctor.
12. **LATE APPOINTMENTS** - If you arrive late to your scheduled appointment, you will be worked back into the schedule if the availability is open if there is no availability you will be asked to reschedule.
13. **RIGHT TO REFUSE SERVICE** - Verbal abuse to any of our doctors or staff will not be tolerated. Foul language and or aggressiveness will lead to immediate termination of your patient/doctor relationship and therefor instates our right to refuse service to you.

I have read and understand the office policies listed above.

_____ _____
Patient/Guardian Signature Date

Office use only: Initial of Employee: _____ Date: _____
Copy given to patient? □No □Yes

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Patient Name:_____
Patient DOB:_____

Porter Medical Associates

REGISTRATION FORM

Please fill out as completely and clearly as possible

ASSIGNMENT OF BENEFITS FORM

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier/s, including Medicare, Medicaid, private insurance and any other health/medical plan, to issue payment checks directly to Porter Medical Associates for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount that is not covered/paid by insurance I further understand that all fees are due and payable on the date that services are rendered.

I further understand that insurance is a contract between my insurance company and myself. Porter Medical Associates is not a third party to this contract, nor do we become involved in disputes regarding covered benefits and copays. I understand that it is my full responsibility to understand my insurance benefits. If coverage is denied I must contact my insurance for inquires. Our office involvement is strictly limited to supplying written documentation to facilitate claims processing.

CONSENT FOR MEDICAL TREATMENT

I have requested medical services from Porter Medical Associates on behalf of myself and/or my dependents. I certify that Porter Medical Associates may perform any procedure for which the physician feels is in my best interest in medical intervention. I understand that some of the procedures performed may be considered as surgical or invasive procedures. Such procedures include, but are not limited to, trigger point injections, lab work, and IV therapy I do understand that I have the right to deny any procedures.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned patient or legally authorized representative ("agent") of the patient acknowledges that he/she personally received a copy of the PORTER MEDICAL ASSOCIATES Notice of Privacy Policies on the date indicated below:

_____ _____

Patient Signature Date

_____

Printed Patient Name

INFORMATION ABOUT AGENT (attach appropriate documentation):

_____ _____

Agent/Representative Title/Relationship Date

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Patient Name:_____
Patient DOB:_____

Porter Medical Associates

Allergy Questionnaire

Name: _____ DOB: _____ Date: _____

The following questionnaire is intended to help define your symptoms and provide valuable information for your doctor. Answer the questions, rating your symptoms to the best of your ability.

1. Consider how severe the problem is when you are experiencing it, and how frequently it happens. Please rate each item below on how "bad" it is by circling the number that best corresponds with how you feel.
2. Please make the most important issue affecting your health (maximum of 3 items).

Allergy Symptoms	No Problem	Very Mild Problem	Mild – Moderate Problem	Moderate Problem	Severe Problem	Problem is as bad as it can be	Place a check mark next to the 3 symptoms affecting you most ✓
1. Sneezing	0	1	2	3	4	5	
2. Runny/Stuffy Nose	0	1	2	3	4	5	
3. Itchy/Watery Eyes	0	1	2	3	4	5	
4. Coughing	0	1	2	3	4	5	
5. Itchy Throat	0	1	2	3	4	5	
6. Post-Nasal Drip	0	1	2	3	4	5	
7. Sinus Pressure / Headaches	0	1	2	3	4	5	
8. Wheezing	0	1	2	3	4	5	
9. Ear Pain / Pressure	0	1	2	3	4	5	
10. Itchy Dry Skin	0	1	2	3	4	5	
Total:							

Scores > 15 should be allergy tested

Patient Name:_____
Patient DOB:_____

Porter Medical Associates

Patient Health Questionnaire-9 (PHQ-9)

Name: _____ Date of Birth: _____ Date: _____

	Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle the appropriate number indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed, or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __0___ + _____ + _____ + _____

=Total Score: _____

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 at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

0	No depression	10-14	Moderate depression
1-4	Minimal depression	15-19	Mod - Severe depression
5-9	Mild depression	20-27	Severe depression

Patient Name:_____
Patient DOB:_____

Porter Medical Associates

Release Of Medical Information

I, _____, date of birth _____ hereby give permission to **Porter Medical Associates** to release any or all of my medical information, including AIDS/HIV, mental health, and alcohol/drug related issues.
to:

Name: Relationship:

1._____

2._____

3._____

4._____

□ Progress Notes as requested
□ Labs and X-rays
□ Correspondence
□ Personal Demographics
□ Diagnosis
□ Other Information_____

_____ _____
Patient/Guardian Signature Date

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Patient Name:_____
Date of Birth: _____
Date:_____

Cognitive Assessment Form

Have you ever experienced:

If Yes, please select how often below symptoms are occurring either daily, weekly, or monthly

• Sensation of not feeling right, being a little confused or unsteady?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Spells you would describe as feeling faint or as if you might pass out?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Events where you've experienced altered awareness?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly

Have you ever experienced:

If Yes, please select how often below symptoms are occurring either daily, weekly, or monthly

• Episodes of temporary confusion or brain fog?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Dizziness accompanied by loss of awareness or confusion?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Difficulty finding the right words or expressing yourself?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Lapse of time or zoning out?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Difficulty recalling the details of conversations you just had or TV shows you just watched?	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly

Have you ever experienced:

Are you experiencing migraines associated with the following symptoms?

• Aura or flashing/shimmering lights, zigzagging lines, or stars	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Dizziness	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Loss of awareness/consciousness	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly
• Nausea	☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Monthly

Do you have history of:

• TBI (Traumatic Brain Injury)	☐ Yes	☐ No
• TIA (Transient Ischemic Attack/ Mini-Stroke)	☐ Yes	☐ No
• Brain concussion or Post-concussion Syndrome	☐ Yes	☐ No
• Dementia	☐ Yes	☐ No
• Stroke	☐ Yes	☐ No
• Brain injury, surgery, or tumors	☐ Yes	☐ No

Physician/ Office Use Only:

Notes: _____

_____

Onset: _____

_____

Patient Signature: _____ Date:_____

Patient Name:_____
Patient DOB:_____

Porter Medical Associates

Neuropathy Screening

Patient Name: _____ DOB: _____ Date: _____

Please take a few minutes to answer the following questions about your legs, and feet. Please check yes or no on how you usually feel.

	YES	NO
1. Are your legs and/or feet numb?		
2. Have you ever had burning sensation in your legs and/or feet?		
3. Are your feet sensitive to touch?		
4. Do you get muscle cramps in your legs and/or feet?		
5. Does it hurt when the bed covers touch your skin?		
6. Do you have difficulty telling the hot water from the cold water when showering/bathing?		
7. Have you ever had an open sore on your foot, not due to injury?		
8. Do you ever feel prickling on your legs and/or feet?		
9. Have you ever been told you have neuropathy?		
10. Do you feel leg/foot weakness and/or fatigue?		
11. Are your symptoms worse at night?		
12. Do your legs hurt when you walk?		
13. Are you unable to sense (feel) your feet when you walk?		
14. Is the skin on your feet so dry that it cracks open?		
15. Have you ever had an amputation?		
16. Have you ever been treated for neuropathy? If yes: What treatment have you had?_____ _____		
17. Do any, or all, of your symptoms as stated above effect your ability to work, exercise, or sleep?		