Dear New Patient,

We have enclosed your new patient paperwork with this letter. Please complete the forms in their entirety. The paperwork may be returned in person, by mail or fax to # (830) 258-7198. You will be contacted once the paperwork is returned to schedule your appointment.

On the day of your appointment, please bring with you:

- Your insurance cards and photo identification (preferably driver’s license).
- Any prescription medicines you are taking (in the original packaging).
- If you use a mail-in prescription service, bring your drug formulary list that shows which medicines they pay for.
- Any over-the-counter supplements.

Thank you for choosing Peterson Medical Associates as your healthcare provider. We look forward to meeting you. If you have any questions, please let us know at 830-258-7762.

Sincerely,

Peterson Medical Associates Staff
# PATIENT INFORMATION SHEET

**Patient Name (last, first, MI):**

**Gender:**
- M
- F

**Date of Birth (MM/DD/YY):**

**Social Security Number:**

**Mailing Address:**

**Home Phone (Primary Y/N):**

**Work Phone:**

**City:**

**State:**

**Zip:**

**Cell Ph #/Pager (Primary Y/N):**

**Marital Status:**

**Ethnicity/Race:**

**Maiden Name:**

**Driver’s License #:**

**Preferred Local Pharmacy:**

**How did you hear about us?**

**Preferred Mail-In Pharmacy:**

**Occupation:**

**Employment Status: (Circle One)**
- Employed
- Full-Time Student
- Part-Time Student
- Retired

**Patient’s Employer:**

**Employer’s Address:**

**Emergency Contact with Phone and Relationship to Contact:**

**Email Address:**

**Spouse’s Name:**

**Spouse’s SSN:**

**Spouses DOB:**

**Spouse’s Employer & Telephone Number:**

**Other Household Members:**

**Responsible Party (Fill out only if other than patient.)**

**Name:**

**Relationship to Patient:**

**Address:**

**Employer & Telephone Number:**

**Home Phone:**

**Cell Phone:**

**Social Security Number:**

**Date of Birth:**

**Health Insurance Information**

**Primary Insurance Health Care Plan:**

**Secondary Insurance Health Care Plan:**

**ID#**

**Group #**

**Name of Policy Holder (last, first, MI):**

**ID#**

**Group #**

**Name of Policy Holder (last, first, MI):**

**Policy Holder’s Address:**

**Policy Holder’s Address:**

**Telephone Number:**

**Date of Birth:**

**Telephone Number:**

**Date of Birth:**

**Social Security Number:**

**Relationship to Patient:**

**Social Security Number:**

**Relationship to Patient:**

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**AFTER CLINIC HOURS (5:00 PM TO 8:00 AM) AND WEEKENDS:** You may reach the ON-CALL PMA Physician by calling our office at 830-258-7762 and following the instructions as given.

**All services rendered are the financial responsibility of the patient or the patient’s parent or guardian. The patient is responsible for payment regardless of insurance coverage. Billing information will be provided to expedite patient reimbursement from private insurance carriers.**

I hereby authorize the provider of services to release information concerning my examination and/or treatment for insurance purposes and to receive direct payment for benefits payable to me for services rendered. I also authorize release of medical information for the purpose of further evaluation or treatment.

**Signature ___________________________________________________________  Date ____________________**
Welcome! We are so glad that you have decided to become a part of our practice. Our goal is to provide you with excellent healthcare in a friendly and compassionate environment. Please take a moment to become familiar with our office’s policies and guidelines, then sign the acknowledgement at the bottom of this page and return it to our office. Thank you for your cooperation.

First Time Visit: Please arrive at least 10 – 15 minutes prior to your appointment time. A nurse will go over your past medical history. Please bring all of your medications in their original containers. If you have co-pay or have not yet met your deductible, please be prepared to pay it when you check in at the front desk. If you are a self-pay patient, payment will be collected after you see the doctor. Payment is due at the time of service.

Follow-Up Visits: Please arrive 5 – 10 minutes before your schedule appointment time. It is our goal for you to be ready to see your physician on time. Follow-ups are scheduled based on the particular needs of specific disease processes. If you have multiple chronic illnesses, you may be scheduled for multiple follow-up visits.

Late Arrivals: We all run late sometimes. In the event that you are late for your appointment, we will try our best to work you back in to the schedule. Depending on how busy we are, you may be required to reschedule your appointment.

Appointment Cancellations: We understand that sometimes plans change. We ask that you reschedule appointments at least 24 hours in advance so that we may give that time to someone else. Although unexpected events may necessitate missing an appointment, if you miss 2 appointments without following the cancellation protocol then you will be charged $25.00. If you miss 3 appointments without following the cancellation protocol, you may be dismissed from the practice. You will receive a written warning notification if you miss 2 appointments.

Sick Visits: Established patients who need acute care should call as early in the day as possible so that we can accommodate you. Patients are seen by appointment only. Depending on the availability of your physician, you may be asked to see another provider.

Medication Refills: For non-emergency, and routine medication refills, please allow 48 hours and ask your pharmacy to send us a refill request. Also, please let a nurse or physician know if you need a 90 day prescription. Narcotic medications will only be written for a 30 day supply at a time. Additional refills to the original prescription will be at the doctor’s discretion. Early refills will not be given. You may be requested to contact your pharmacy to ask them to fax a refill request to our office to assure that exact fill dates are documented accurately. You may also be asked for a follow-up appointment for certain refill requests.

AFTER CLINIC HOURS (5:00 PM TO 8:00 AM) AND WEEKENDS: You may reach the ON-CALL PMA Physician by calling our office at 830-258-7762 and following the instructions as given.

Please remember that your appointment is to focus on your medical needs. If your family member, who is also our patient, has any medical needs (including medication refills), we will be happy to schedule an appointment for them at the conclusion of your office visit.

As a courtesy, please turn off or silence your cell phone during your office visit.

I have read and understand the above office policies and agree to abide by them.

___________________________________    ________________________
Signature                         Date
PATIENT AUTHORIZATION FOR CONTACT & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name ____________________________ Date of Birth __________________

THIS FORM INSTRUCTS US WHO ELSE SHOULD GET YOUR MEDICAL INFORMATION. YOUR DOCTORS ARE ALWAYS INFORMED, SO DO NOT LIST THEM.

1. I authorize Peterson Medical Associates to disclose my protected health information to:

   _______ Family member(s) (List): _________________________ Ph #: _____________________
   ____________________________________________ Ph #: _____________________
   _______ Non-family member(s) (List): _____________________ Ph #: _____________________
   _______ Myself only

2. I authorize the practice to disclose only the following protected health information to the individual(s) listed above:

   _______ Test results, reports, and general health updates
   _______ Nothing beyond general health questions & updates

3. I may be contacted with medical information by:

   e-mail: __________________________________________
   _______ Please send a detailed message to my email address.
   _______ Please send a message that only includes a call-back number and name at the doctor’s office.

   Home: ____________________________ Cell: ____________________________
   _______ Please leave a detailed message on my answering machine/voice mail.
   _______ Please leave information with any of the individuals listed above.
   _______ Please leave a message with only call-back information with either an individual or on my answering machine / voice mail. Call back information will include doctor’s name and staff member’s name.

Expiration or termination of authorization – This authorization will remain in effect until terminated by patient’s personal representative, or another individual of legal entity authorized to do so by court order or law.

Right to revoke or terminate – As stated in our Notice of Privacy practices, you have the right to revoke or terminate authorization by submitting a written request to our Privacy Manager.

________________________________________   ____________________________
Patient Signature       Date
**PLEASE CIRCLE THE MEDICAL PROBLEMS/COMPLAINTS YOU ARE HAVING TODAY**

<table>
<thead>
<tr>
<th>NAME ____________________</th>
<th>DATE OF BIRTH ______________</th>
<th>AGE ____</th>
<th>DATE ______________</th>
</tr>
</thead>
</table>

**CONSTITUTIONAL**
- fatigue
- fever
- chills
- malaise
- body aches

**EYES**
- discharge from eye
- eye discomfort
- eye pain
- changes in vision
- foreign body sensation

**HENT**
- headaches
- vertigo
- lightheadedness
- recent head injury
- sinus pain
- nasal congestion
- nose bleeding
- nasal discharge
- postnasal drip
- sore throat
- ear pain
- ear fullness
- oral lesions
- painful swallowing

**CARDIOVASCULAR**
- chest pain
- irregular heart beats
- rapid heart rate
- shortness of breath on exertion
- swelling of legs
- dizziness

**RESPIRATORY**
- shortness of breath
- wheezing
- cough:
  - dry or productive
- hoarseness

**GASTROINTESTINAL**
- nausea
- vomiting
- diarrhea
- constipation
- loss of appetite
- heartburn
- reflux
- hematemesis
- excessive belching
- abdominal pain
- jaundice
- blood in stools
- hematochezia
- melena
- hemorrhoids
- fatty stools
- tenesmus
- excessive flatulence
- bloating
- early satiety
- retching
- fecal incontinence
- changes in caliber stool
- difficulty swallowing

**GENITOURINARY**
- urgency
- frequency
- dysuria
- nocturia
- hematuria
- change in urine color
- incontinence
- difficulty voiding
- urinary hesitancy
- decreased stream
- post-voiding dribbling
- decreased libido
- genital sores
- irregular menses
- dysmenorrhea
- menorrhagia
- metrorrhagia
- vaginal discharge
- possible pregnancy
- amenorrhea
- hot flashes
- impotence
- scrotal pain / scrotal mass / penile lesions / penile discharge
- painful intercourse
- hernia

**INTEGUMENT**
- rash
- itching
- pigmentation
- skin dryness
- nail changes
- new skin lesions
- changes of existing lesions
- seizures
- hair changes
- tremors
- loss of balance

**NEUROLOGIC**
- altered mental status
- muscular weakness
- incoordination
- tingling or numbness
- memory difficulties
- speech difficulties

**MUSCULOSKELETAL**
- joint pain
- joint swelling
- muscle pain
- limitation of motion
- muscular weakness
- muscle cramps
- neck pain
- back pain
- shoulder pain
- elbow pain
- wrist pain
- hip pain
- knee pain
- ankle pain
- foot pain
- muscle spasms

**ENDOCRINE**
- loss of hair
- cold intolerance
- heat intolerance
- central obesity
- excessive urination
- excessive thirst

**EMO**
- anxiety
- depression
- hallucinations
- feeling confused
- difficulty sleeping
- compulsive behavior
- suicidal ideation
- homicidal ideation
- excessive anger
- withdrawn

**HEMELYMPH**
- easy bleeding
- easy bruising
- lymph node enlargement

**ALLERGY IMMUNOLOGY**
- sinus allergy symptoms
- allergic dermatitis

**INTEGUMENT**
- rash
- itching
- pigmentation
- skin dryness
- nail changes
- new skin lesions
- changes of existing lesions
- seizures
- hair changes
- tremors
- loss of balance

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- elbow pain
- wrist pain
- hip pain
- knee pain
- ankle pain
- foot pain
- muscle spasms

List Additional Symptoms: _________________________________________________________________
______________________________________________________________________________________
PAST MEDICAL HISTORY
(Circle all that apply)
*Cancer (yes / no) Type: _____________
*No pertinent Past Medical History
Asthma
BPH (enlarged Prostate)
CHF
Colon Polyps
Constipation
COPD
Diabetes Mellitus, Type II
Erectile Dysfunction
GERD
Heart Disease
High Blood Pressure
High Cholesterol
Hyperthyroidism, Acquired
Hypothyroidism
IBS
Kidney Disease
Menopausal Syndrome
Osteoarthritis
Peripheral Neuropathy
Peripheral Vascular Disease
Rheumatoid Arthritis
Seizure Disorder
Stroke
Ulcerative Colitis
Urinary Incontinence
Vertigo
Other:____________________

PREVENTATIVE SERVICES
(date last performed)
Bone Density (DEXA) _____________
Lipid/Cholesterol _____________
Mammogram _____________
Pap Smear _____________
PSA/Prostate _____________
Sigmoidoscopy _____________
Colonoscopy _____________
PAST SURGICAL HISTORY
(list ALL surgeries with reason and date)
____________________________________
____________________________________
____________________________________
____________________________________

GYNECOLOGIC HISTORY
# Pregnancies __; # Deliveries __; # Miscarriages __

IMMUNIZATIONS
Flu (Y / N) Date: _____________
Pneumonia (Y / N) Date: _____________
Shingles (Zostavax) (Y / N) Date: _____________
Tetanus (Y / N) Date: _____________

FAMILY MEDICAL HISTORY
Indicate which family member: father, mother, sister, brother, maternal grandparent, paternal grandparent, aunt/uncle
*Cancer ______ Where?
Alcoholism _____________
Asthma _____________
Bleeding/Clotting _____________
COPD _____________
Depression _____________
Diabetes Mellitus _____________
Heart Disease _____________
High Blood Pressure _____________
High Cholesterol _____________
Kidney Disease _____________
Liver Disease _____________
Obesity _____________
Suicide _____________
Deceased Immediate Family Members
Mother:
   Cause _____________ Age ______
Father:
   Cause _____________ Age ______
Brother:
   Cause _____________ Age ______
Sister:
   Cause _____________ Age ______

SOCIAL HISTORY
Education Level _____________
Exercise level (circle) None / Low / Moderate / High
Infection Risk (circle) HIV / MRSA / Hep B
Marital Status (circle) Single / Married / Divorced / Widowed
Occupation _____________
Substance Use:
   Alcohol: yes / no Drinks/week ______
   Tobacco: never / yes Packs/day ______
   Other substance use: _____________

OTHER PHYSICIANS
____________________________________
____________________________________
____________________________________
Patient PRESCRIPTION MEDICATION List

**Please list any ALLERGIES to Medications:**

<table>
<thead>
<tr>
<th>Current Medications</th>
<th>Dose (ex. mg or mcg)</th>
<th>How Taken? (mouth or injection)</th>
<th>How many times taken daily?</th>
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Patient “OVER THE COUNTER / SUPPLEMENT” List

<table>
<thead>
<tr>
<th>Name Supplement / Vitamin</th>
<th>Dose (ex: mg or mcg)</th>
<th>How many times taken daily?</th>
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Authorization for Release of Medical Information

Name: ________________________________________
Date of Birth: ______________________
Address: _______________________________________
City: _________________    State: ______  Zip: _______

I hereby authorize (please list physician name and/or facility):

Dr. Name/Facility Name: _____________________________________
Address: ___________________________________________________
City:  ______________________________________________________
State: _______________________  Zip: _____________
Phone#: ______________________   Fax #: ______________________

Please send only the most recent of the following:

Colonoscopies    Dexa Scans / Bone Density
Labs              Mammograms
PE / Wellness     Pap
Progress Note     Stress Tests
Xrays / Scans     Immunization Record
Living Wills, POA Other: ___________________________________

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed.

______________________________________  ______________________
Signature       Date
Expires: ________________________________
Witness: ________________________________

This medical record may contain information about drug abuse, alcohol abuse, venereal disease, abortion, or mental health treatment. Separate consent must be given before this information can be released.

☐ DO consent / ☐ DO NOT consent to have this information disclosed.

______________________________________  ______________________
Signature       Date

This medical record may contain information concerning HIV testing and/or AIDS diagnosis treatment. Separate consent must be given before this information can be released.

☐ DO consent / ☐ DO NOT consent to have this information disclosed.

______________________________________  ______________________
Signature       Date
PATIENT CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I understand that as a part of the provision of healthcare services, Peterson Medical Associates creates and maintains health records and other information describing among other things, my health history, symptoms, examination, and test results, diagnosis's, treatment, and any plans for future care or treatment.

The Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information is posted on the first floor at 575 Hill Country Drive in the foyer. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their privacy practices and the terms of this notice at any time. Upon your request, we will provide you with any revised Notice of Privacy Practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations (quality assessment and services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and healthcare operations. I have the right to revoke this consent in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.

2. A photocopy or fax of this consent is as valid as the original.

3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or healthcare operations, be restricted. I also understand that the Practice and I must agree to any restrictions in writing that I request on the use and disclosure of my Protected Health Information which have been previously agreed upon.

_________________________________________ ______________________________________
PATIENT OR PERSONAL REPRESENTATIVE    DATE
OR GUARDIAN’S NAME PRINTED

_________________________________________ ______________________________________
PATIENT OR PERSONAL REPRESENTATIVE     SOCIAL SECURITY NUMBER
OR GUARDIAN SIGNATURE          (FOR IDENTIFICATION PURPOSES ONLY)

_________________________________________ ______________________________________
WITNESS      DATE
PEDIATRIC INTAKE FORM

Patient’s name: ____________________________________                       Today’s date:  ________________

Age: _______                                    Date of Birth: ____________                                  Gender:  Female / Male

Reason for today’s visit:  ______________________________________________________________________

Prenatal History
Mother’s age at child’s birth: _____    Mother’s health during pregnancy (circle any that apply):  bleeding, hypertension, diabetes, cigarettes, alcohol, drug use, thyroid problems, medications, illnesses, physical trauma

Birth History
Term: (circle) Full    Premature    Late                Length of labor: __________    Birth Weight:  _____________
Did your child have any of the following problems shortly after birth?  (circle any that apply):  rashes, jaundice, colic, birth injuries, seizures, fever, cerebral palsy, blue baby, birth defect, other (specify)___________________
Breast fed?  Yes / No   If yes, how long? _________    Formula type:   milk     soy     other
Any food allergies noted so far?  (specify)_________________________________________________________
Age began:  sitting __________    crawling __________    walking __________    talking ___________

Diet/Exercise
What is your child’s main source of fluid intake?  ________________     Favorite food:  _____________________
Does your child drink sodas of any kind?   Yes / No          If yes, how many per day?  _______
Does your child eat fast food more than twice per week?   Yes / No   If yes, how many times per week? _______
Does your child participate in any regular sports activity?   Yes / No   Which sport(s)? _____________________

School Environment
What type of school does your child attend?    Public     Private     Homeschool     Other                Grade: ______
Is your child currently experiencing any academic difficulties?   Yes / No   If yes, please describe briefly:_________________________________________________________________________________________

Medical History
Medication allergies: (list) _________________________  Environmental allergies: _________________________
Has your child had or have: (circle) chicken pox, pneumonia, rheumatic fever, frequent colds, tonsillitis (# of times), ear infections (# of times), strep throat (# of times), asthma, diabetes, head concussion
List any medications your child is currently taking: _____________________________________________________

Has your child had any of the following:(circle) hearing test, speech or language test, psychological evaluation, electroencephalogram(EEG), injuries requiring surgery or hospitalization?  Please list:  ______________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

Does your child wear glasses, contact lenses, braces, retainers, or any prosthesis? ___________________________

Does your child use a seat belt or sit in a child safety seat EVERY time they ride in a car?   Yes / No

Does your child wear a helmet when he/she rides a bike?   Yes / No

Did you bring your child’s immunization record with you today?   Yes/ No
PEDIATRIC REGISTRATION FORM

Patient Name: ___________________________       Date of Birth:  ______________       Date: ________________

IF EITHER PARENT HAS A DIFFERENT LAST NAME THAN ABOVE, PLEASE INDICATE:

Patient’s address:  ________________________________________________________________

Home telephone: _______________ Parent Cell: ______________Parent(s) work phone: _______________

Parent’s email address:  ______________________________________ Patient’s Age: ____________

Preferred pharmacy:  _____________________________                        City:  ________________________

Mother/Guardian:  _______________________   Date of Birth: _____________   SS#: __________________

Father/Guardian:  ________________________  Date of Birth: _____________   SS#: __________________

Father’s Employer: ________________________________ Work phone: _________________________

Mother’s Employer: ________________________________  Work phone: _______________________

Primary Insurance Co: ________________________  Address:___________________________________

Policy #: _____________________________ID#: _______________Group #: ____________ Effective Date:____________

Policy Holder: _____________________________           Office visit co-pay amount:  ___________

Emergency contact:  __________________________   Relationship to patient: ____________________

Phone #: ___________________        Responsible Party’s Driver’s License #:_________________________

How did you hear about our practice?

I understand that I am responsible for all professional services performed by the physician or his staff. I am responsible for all services not covered or denied by my insurance company. Copayments are due at time of visit.

X________________________________                                  Date________________________