



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

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

When did problem begin: \_\_\_\_\_ Which side:  Right  Left

How did the pain begin: \_\_\_\_\_ Does it wak you up at night? Yes No

What makes the pain worse: \_\_\_\_\_

What makes the pain better: \_\_\_\_\_

Have you had any (circle): X-rays MRI CT scan BoneScan EMG Other: \_\_\_\_\_

When \_\_\_\_\_ Where \_\_\_\_\_ Ordered by: \_\_\_\_\_

Have you had any Physical Therapy:  Yes  No Are you still working? Yes No Light duty

Have you been hospitalized for this problem:  Yes  No By whom: \_\_\_\_\_

**Medical History:** (continue on back if needed)

Medical Problems: \_\_\_\_\_

\_\_\_\_\_

**IMPORTANT:** Please list all medication, vitamins, OTC pain relievers, or any other substance taken orally on a regular basis.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Drug, Tape or Dye Allergies:** \_\_\_\_\_

Previous surgeries: \_\_\_\_\_

\_\_\_\_\_

Have you ever had a blood transfusion: Yes No

**Family/Social History**

Does anyone in your family have a history of: (circle)

Heart Disease Diabetes Arthritis Stroke

Kidney trouble Muscular disease Mental Illness Other: \_\_\_\_\_

Substance Abuse Cancer (please specify): \_\_\_\_\_

Parent's age and health (if deceased: age at death and cause):

Do you smoke?  Yes  No How much? \_\_\_\_\_ Have you ever smoked?  Current  Former  Never

Do you drink?  Yes  No How much? \_\_\_\_\_

**Females:** Is there any possibility you are pregnant?  Yes  No

Are you experiencing any of the following? (circle)

Fever Hearing Loss Depression Skin infections Weight Loss Vision Loss

Insomnia Painful Urination Neight Sweats Heartburn Adnormal bleeding

Blood in Urine Chest Pain Loss of Appetite Cough Irrigular Heart Beat

Dizziness Shortness of Breath Rashes Seizures Wheezing

Reviewed: \_\_\_\_\_

# PRIVIA MEDICAL GROUP NORTH TEXAS

PHYSICIAN: \_\_\_\_\_ BEING SEEN TODAY

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

## PATIENT REGISTRATION INFORMATION

If Patient cannot be billed for these services (for example, minor children), please complete RESPONSIBLE PARTY SECTION below as well as this patient registration information section.

Social Security #: \_\_\_\_\_ Driver's License # \_\_\_\_\_ State: \_\_\_\_\_  
Name: \_\_\_\_\_ MM DD YY  
LAST FIRST MI SEX DATE OF BIRTH AGE S M D W O MARITAL STATUS  
Address: \_\_\_\_\_ ( ) \_\_\_\_\_  
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE  
Alt/Cell Phone: ( ) \_\_\_\_\_ Day Phone: ( ) \_\_\_\_\_ Email: \_\_\_\_\_  
Race \_\_\_\_\_ Language \_\_\_\_\_ Ethnicity  Hispanic/Latin  Non Hispanic/Latin

Full-Time Part-Time Retired Unemployed Student Employer's Name: \_\_\_\_\_  
EMPLOYMENT STATUS (PLEASE CIRCLE ONE) or School

Employer's Address: \_\_\_\_\_  
MAILING ADDRESS CITY ST ZIP

Occupation: \_\_\_\_\_

Emergency Contact: (Please indicate a friend or relative not living at the same address.)

\_\_\_\_\_ ( ) \_\_\_\_\_  
NAME RELATIONSHIP EMERGENCY CONTACT #

## RESPONSIBLE PARTY AND BILLING INFORMATION

Patient is responsible unless a minor child or guardian. RESPONSIBLE PARTY SECTION must be completed.

Patient Relationship to Responsible Party: Child \_\_\_\_\_ Other \_\_\_\_\_ Resp. Party SS #: \_\_\_\_\_  
SPECIFY

Name: \_\_\_\_\_ MM DD YY  
LAST FIRST MI SEX DATE OF BIRTH AGE S M D W O MARITAL STATUS

Address: \_\_\_\_\_ ( ) \_\_\_\_\_  
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE

Full-Time Part-Time Retired Unemployed Student Employer's Name: \_\_\_\_\_  
EMPLOYMENT STATUS (PLEASE CIRCLE ONE) or School

Employer's Address: \_\_\_\_\_  
MAILING ADDRESS CITY ST ZIP

Occupation: \_\_\_\_\_ ( ) \_\_\_\_\_ ( )  
WORK PHONE EXT

## OTHER PATIENT INFORMATION

Spouse's Name: \_\_\_\_\_ Employer: \_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ Spouse's Work Phone: ( ) \_\_\_\_\_ ( ) Occupation: \_\_\_\_\_  
DATE OF BIRTH EXT

## PRIMARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: \_\_\_\_\_ Address: \_\_\_\_\_ ( ) \_\_\_\_\_  
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) \_\_\_\_\_  
CITY ST ZIP

Primary Care Physician: \_\_\_\_\_

Policy Holder: \_\_\_\_\_  
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_  
(SPECIFY)

Employer's Name: \_\_\_\_\_  
INSUREDS ID GROUP NAME AND/OR NUMBER

Address: \_\_\_\_\_  
THC99P02 STREET CITY ST ZIP

## SECONDARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: \_\_\_\_\_ Address: \_\_\_\_\_ ( ) \_\_\_\_\_  
STREET or P.O. BOX PHONE  
Co-Pay Amount: (if applicable) \_\_\_\_\_ CITY ST ZIP  
Primary Care Physician: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_  
LAST FIRST MI SEX DATE OF BIRTH SS #  
Patient Relationship to Insured Party: Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other \_\_\_\_\_  
Employer's Name: \_\_\_\_\_ (SPECIFY)  
Employer's Address: \_\_\_\_\_ INSUREDS ID GROUP NAME AND/OR NUMBER  
STREET CITY ST ZIP

## WORKER'S COMPENSATION

Worker's Compensation Insurance Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Adj. \_\_\_\_\_  
Claim #: \_\_\_\_\_ DOI \_\_\_\_\_ Phone \_\_\_\_\_  
What Employer: \_\_\_\_\_

## ACCIDENT INFORMATION

Was this the result of an accident? \_\_\_ Yes \_\_\_ No Where did it occur? \_\_\_ At Work \_\_\_ Auto Accident \_\_\_ Other  
Date of Accident \_\_\_\_\_ Have you reported this injury to your employer? \_\_\_ Yes \_\_\_ No When \_\_\_\_\_  
Describe accident briefly: \_\_\_\_\_  
Do you have an attorney representing you? \_\_\_ Yes \_\_\_ No Who is the attorney? \_\_\_\_\_

## REFERRAL INFORMATION

Who referred you? \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Family Physician \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

## ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES/APPOINTMENT OF AUTHORIZED REPRESENTATIVE

### PLEASE READ

Privia Medical Group North Texas (PMG), and its physicians are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been advised that PMG has such a Notice of Privacy Practices.

I hereby assign, transfer and set over to PMG, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I am also financially responsible for any balances due after payments by my insurance company.

I appoint PMG to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS SIGNATURE