TODAY'S DATE____________________

Lawrence A. Alder, M.D., PLLC

144 Fairway Drive, Suite A
Kerrville, TX. 78028
O: 830.257.5500 ~ F: 830.257.5501

New Patient Packet

PLEASE PRINT

Last Name ____________________________ First Name ___________________________. MI_____

Address________________________________ Home Phone_______________ Cell__________________

City ____ State___________ Zip____________________

Date of Birth_________________ Sex_______ Race_________ Preferred Method(s) of Contact ☐ None ☐ Text ☐ Cell ☐ Home Phone ☐ Email

Social Security Number ______________________ Email Address_____________________________________

Marital Status ☐ M ☐ S ☐ W ☐ D ☐ Sep   Spouse/Partner's Name ______________________________

Occupation ____

Employer/Business __________________________________ Work/Daytime Phone______________________

Whom May We Thank for Your Visit ____

CLOSEST RELATIVE OR FRIEND IN CASE OF EMERGENCY

Name____ Relationship____________________________

Home Phone______________________________________ Cell ___________________________________

INSURANCE INFORMATION

PRIMARY INSURANCE NAME ____

Policy Number________________________________ Group Number ________________________________

Insurance Company Address ____

Policy Holder's Name____ Date of Birth_______________________

Policy Holder Social Security Number __________________________ Relationship to Patient ________________

SECONDARY INSURANCE NAME____

Policy Number____ Group Number __________________________

Insurance Company Address____

Policy Holder's Name_______________________________________ Date of Birth__________________________

Policy Holder Social Security Number__________________________ Relationship to Patient ___________________

PRINT NAME______________________________

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PAST MEDICAL HISTORY

PLEASE CHECK ALL THAT APPLY:

- ☐ Abnormal Pap Smears
- ☐ Abnormal Heart Beat
- ☐ Acid Reflux
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis (type)_____________
- ☐ Atrial Fibrillation/A-Fib
- ☐ B-12 Deficiency
- ☐ Bipolar Disorder
- ☐ Blood Disorder
- ☐ Cancer (type)____________
- ☐ Colon Polyps
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Chronic Kidney Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Genital Herpes
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Liver Disease
- ☐ Seizures
- ☐ Shingles
- ☐ Stroke
- ☐ TB
- ☐ Thyroid Disorder
- ☐ Ulcers

OBSETETRIC & GYNECOLOGICAL HISTORY

PLEASE CHECK ALL THAT APPLY:

☐ Pre-Menopausal
Date Last Menstrual Cycle________________

☐ Post-Menopausal
Age at Menopause_____________

☐ Hormone Replacement Therapy
Medication Name______________________

☐ Number of Times Pregnant
Live Births ______ Miscarriages______
Age(s) of Children_________________

☐ Hysterectomy
☐ Total ☐ Partial

IMMUNIZATION HISTORY

PLEASE LIST ALL DATES:

Influenza__________________________

Pneumovax 23_____________________

Prevnar 13________________________

Shingrix__________________________

TD_________________________________

Tdap_______________________________

Zostavax___________________________

Other______________________________

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HISTORY PROCEDURES

PLEASE READ CAREFULLY & LIST ALL APPLICABLE DATES

Preventive	Month/Year
Colonoscopy	________________
DEXA	________________
EKG	________________
Eye Exam	________________
Labs	________________
Mammogram	________________
Pap Smear	________________
Physical	________________
Prostate Check	________________
Other	________________

List all Surgeries	Year
________________	________________
________________	________________
________________	________________
________________	________________
________________	________________

Non-Surgical Hospitalizations	Year
________________	________________
________________	________________
________________	________________
________________	________________
________________	________________

List All Providers You See, Their Specialty, and Phone Numbers

Provider & Specialty	Phone Number
________________	________________
________________	________________
________________	________________
________________	________________

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Social History

PLEASE CHECK AND ANSWER ALL THAT APPLY:

☐ Tobacco Use
- ☐ Current Packs/day_______
- ☐ Former Packs/day_______ Year Quit_____

☐ Alcohol
- ☐ Current Drinks/day ______ How Often_______
- ☐ Former Drinks/day_______ Years Drank_______ Year Quit_______

☐ Hobbies (Please List) ___________________
____
____
____
____

☐ Are You on a Special Diet
Please explain____________________

☐ Exercise Frequency________________
What type_______________________
____

☐ Illicit Drug Use
- ☐ Current User How Often_______
  Drug(s) of Choice_______________
  ____
- ☐ Former User Year Quit__________
  Drug(s) OF Choice____________
  ____

Medication Allergies

Medication	☐ **N/A**	**Reproduction**
________________________		____________________________
________________________		____________________________
________________________		____________________________

Environmental Allergies

Environmental Element	☐ **N/A**	**Reaction**
________________________		____________________________
________________________		____________________________
________________________		____________________________
________________________		____________________________

Food Allergies

Food Product	☐ **N/A**	**Reaction**
________________________		____________________________
________________________		____________________________
________________________		____________________________
________________________		____________________________

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MEDICATION LIST

Medication Name	Dosage	Qty	Frequency	Reason for Medication

PREFERRED PHARMACY

Name:____

Location/Zip Code:____________________________________

Name of Mail Order Pharmacy (if applicable):_______________

PRINT NAME______________________________

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FAMILY HISTORY

PLEASE CHECK ALL THAT APPLY

	Father	Mother	Sibling	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcoholism							
Anemia							
Anxiety							
Arthritis							
Asthma							
Autoimmune Disease							
B-12 Deficiency							
Blood Disorder							
COPD							
Cancer							
Depression							
Diabetes							
Drug Abuse							
Epilepsy							
Glaucoma							
Heart Disease							
High Cholesterol							
High Blood Pressure							
Low Blood Sugar							
Stroke							
Thyroid Disease							

IMMEDIATE FAMILY

Mother: ☐ Living ☐ Deceased Age_________
Father: ☐ Living ☐ Deceased Age_________

Sister(s): ☐ Living ☐ Deceased. Age(s)____________
Brother(s): ☐ Living ☐ Deceased. Age(s)____________

Do Any Diseases Run in Your Family? ☐ *Yes
☐ No

*If Not Already Listed Above, Please Describe____

____

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Financial Policy

PLEASE INITIAL EACH SECTION:

_______Payment and or copay/deductible is due at the time of service.

______I, the undersigned, hereby authorize the payment of medical benefits, including Medicare, Medicaid, private insurance and any other health or medical plan, directly to the provider for services provided to me. I agree and acknowledge that my signature on this document authorizes the provider to submit claims for services rendered and services to be rendered without obtaining my signature on each claim to be submitted for myself and/or my dependents. I will be bound by this signature as though I had signed the claim.

________I understand that insurance is considered a method of reimbursing the doctor for services rendered and is not considered a substitute for payment. Some insurance companies pay fixed allowances for certain procedures and other insurance companies pay only a percentage of the charge. I understand that I am financially responsible for any deductible amount, co-insurance, out-of-network percentage, and/or any other balance not covered by my insurance company.

________I authorize the release to my insurance company any information concerning my healthcare, advice, treatment or supplies provided to me. This information will be used for reevaluating and administering claims and benefits.

The insurance information furnished herein represents a full disclosure of the insurance/third party benefits to which I am entitled. I further understand that failure to disclose or furnish full and complete insurance, Medicare, Medicaid information or pre-certification/second opinion requirements for all plans in which I subscribe may cause me to incur a liability for professional charges due to the non-payment of any carrier.

A photocopy of this assignment shall have the same force and effect as the form bearing the patient's original signature.

Printed Patient Name____

Patient Signature_________________________________ Date____________________

PRINT NAME________________________

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Medical Information Release Form
(HIPPA)

Patient Name________________________________ DOB____________________

Release of Information

PLEASE INITIAL APPROPRIATE SECTION

_______I authorize the release of information including, but not limited to, diagnosis, records, examinations rendered to me and any claims information to the following individual(s):

Name______________________________ DOB_______________ Relationship___________

Name______________________________ DOB_______________ Relationship___________

Name______________________________ DOB_______________ Relationship___________

________Information is **NOT** to be released to anyone.

Patient Notification

PLEASE INITIAL AND LIST ALL THAT APPLY

_____I would like your office to contact me via
☐ Home ☐ Cell ☐ Work ☐ Other____________________
____

It is okay to leave a message with detailed information at:

____

It is not okay to leave a message with detailed information at

____

Patient Signature______________________________ Date____________________

PRINT NAME____________________________

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Medication Refill

Within two working days, our office will process a request for the refill of your medication. There are several situations when an office visit may be required to obtain a medication refill. For controlled medications, a urine drug screen may also be required. Please understand that we have no control on the time a pharmacy takes to process and prepare your prescription.

Medication Coverage by Insurance

If a medication is not covered by your insurance, you may elect to either pay for the medication directly or work with us to obtain another medication for your condition. If that is the case, you will need to present to our office your medication formulary. We will regularly review your medicines and determine whether they are safe and appropriate for you.

When appropriate, we may file an appeal with your insurance company. Your insurance carrier may or may not agree to cover your prescription. We do not control any insurance decision and we cannot force an insurance company to pay a part of any prescription. Appeals are a lengthy and arduous process. Usually, your medical records, as well as a detailed letter justifying the need for a medication is required for the insurance company to review a request for a specific medication. Please be aware that the insurance company does not determine if a medication is appropriate, only if they will pay all or a part of the cost of the medication.

Thank you for working with us. Our goal is to provide you with excellent medical care. If you have a concern with any of your medication(s), please don't hesitate to let us know.

Printed Patient Name____

Patient Signature____ Date_______________

PRINT NAME___________________________

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Medical Records Release

Patient Name____

DOB________________________________ SSN________________________________

I hereby authorize____

____

To release my medical records to **Dr. Lawrence A. Alder** my most recent

☐ **ENTIRE RECORD**

☐ Progress notes

☐ Labs

☐ Imaging

☐ EKG

☐ Colonoscopy

☐ Other______________________________

____

____

I understand that my records are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law. I also understand that I may revoke this authorization at any time.

This authorization will expire one (1) year from the date of my signature.

Patient Signature ____ Date____________________

Relationship to Patient ____ Date____________________