signature MD

TODAY'S DATE_____

Lawrence A. Alder, M.D., PLLC

703 Hill Country Dr., Ste. 101
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 _____

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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	Reaction
_____		_____
_____		_____
_____		_____

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):_____

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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_____