Total Care Family Practice

Evan C. Allen, MD

2510 Wigwam Parkway, Suite 201
Henderson, NV 89074
Phone # (702) 541 - 8240
Fax # (702) 541 - 8241

Demographics

Last Name:_____ First Name:_____
What would you like to be called:_____
Marital Status: ☐ Single ☐ Married ☐ Other Gender: ☐ Male ☐ Female DOB:_____
Social Security:_____ Email:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Home Ph:_____ Cell Ph:_____

Employment status:
☐ Employed ☐ Retired ☐ Unemployed ☐ Other
Patient's Employer:_____ Wk. Phone:_____
Address:_____
City:_____ State:_____ Zip Code:_____

Partners Name:_____ Ph:_____
Emergency Contact:_____ **Ph:**_____
Relationship:_____ May we release Medical Information to Emergency Contact:_____

INSURANCE INFORMATION-PRIMARY INSURANCE

Insured name:_____
Policy #_____ Group #_____
Are you the policy holder? If not please fill out the following:
Guarantor's Name:_____ Date of Birth:_____

INSURANCE INFORMATION-SECONDARY INSURANCE

Insured name:_____
Policy #_____ Group #_____
Are you the policy holder? If not please fill out the following:
Guarantor's Name:_____ Date of Birth:_____

How did you hear about us:_____

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Medical Information

Problems to discuss today:_____

Medical History: Check any past or current medical problems

☐ **High blood pressure**	☐ **Diabetes**	☐ **Heart murmur**	☐ **Angina**	☐ **Heart attack**
☐ **Tuberculosis**	☐ **Asthma**	☐ **Pneumonia**	☐ **Bronchitis**	☐ **Thyroid disease**
☐ **Anemia**	☐ **Glaucoma**	☐ **Cancer**	☐ **Osteoporosis**	☐ **Seizures**
☐ **Kidney infections**	☐ **Depression**	☐ **Headache**	☐ **Arthritis**	☐ **Hepatitis**

Any other significant medical problems:_____

_____.

Previous surgeries (include dates):_____

_____.

Allergies to medications:_____.

Family members medical History: Check any past or current medical problems

☐ **High blood pressure**	☐ **Diabetes**	☐ **Heart murmur**	☐ **Angina**	☐ **Heart attack**
☐ **Tuberculosis**	☐ **Asthma**	☐ **Pneumonia**	☐ **Bronchitis**	☐ **Thyroid disease**
☐ **Anemia**	☐ **Glaucoma**	☐ **Cancer**	☐ **Osteoporosis**	☐ **Seizures**
☐ **Kidney infections**	☐ **Depression**	☐ **Headache**	☐ **Arthritis**	☐ **Hepatitis**

Patients most recently had each of the following test:

Colonoscopy:	Never	☐	1-3 months	☐	3-6 months	☐	1 year	☐	More than 2 years ☐
Flu Shot:	Never	☐	1-3 months	☐	3-6 months	☐	1 year	☐	More than 2 years ☐
Physical Exam:	Never	☐	1-3 months	☐	3-6 months	☐	1 year	☐	More than 2 years ☐
Pneumonia Shot:	Never	☐	1-3 months	☐	3-6 months	☐	1 year	☐	More than 2 years ☐
Tetanus Shot:	Never	☐	1-3 months	☐	3-6 months	☐	1 year	☐	More than 2 years ☐
PSA Test:	Never	☐	1-3 months	☐	3-6 months	☐	1 year	☐	More than 2 years ☐
Yearly fasting labs:	Never		1-3 months	☐	3-6 months		1 year	☐	More than 2 years ☐

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Do you:

Use of Alcohol: Never ☐ Drinks/Weekly_____ Quit when_____

Use of Caffeine, cups per day: Coffee_____ Tea_____ Soda_____ Energy Drink_____

Use of Tobacco: Never ☐ Quit when_____ Current Packs/Day_____

Use of Drugs: Never ☐ Quit when_____ Current Packs/Day_____

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS

The above information is complete and correct. I authorize release of information necessary to file a claim with my insurance and I assign benefits to Total Care Family Practice. We will gladly file your insurance claim, however payment for co-pays and deductibles are required at the time services are rendered. We cannot guarantee payment to Total Care Family Practice. We have an agreement with you, not your insurance company for payment. In the event your insurance company denies a claim, you will become responsible for services rendered to a minor. If your account is turned over for outside collections, you will be responsible for all costs of the outside collections agency. I authorize release of all medical records to referring and primary care physicians and the insurance company, as applicable. I authorize fax transmission of medical records of necessary.

Signature:_____ **Date:**_____

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Service and Policies

Initial:_____ **Financial and Billing Responsibilities:** All co-payments, co-insurance, deductibles and balances are due at the time of service and will be collected at check-in. We accept cash, credit, and debit cards for payment at check-in. No exceptions will be made. Visits or procedures that are not covered by insurance will be paid at the time of that visit. We provide receipts for every patient. Please ask for a receipt at the time of check-out. You should present your insurance card at each visit. If your insurance status changes you must notify the office immediately or be financially responsible for all services rendered. If your insurance company does not pay within 60 days, we reserve the right to begin billing you directly. All accounts will be considered delinquent after 90 days. These accounts will be placed with a collection agency and will be subject to all collection and court costs necessary to collect the outstanding balance.

Initial:_____ **Appointment Cancellations:** We require a 24 hours cancellation notice or a $50 fee will be assessed for the office visit. There is a $75 fee for in office procedures and a $175 fee for ultrasound procedures.

Initial:_____ **Late Arrivals:** If you are more than 7 minutes late, your appointment may be rescheduled. If we have to reschedule you for another day, there will be a $50 same day cancellation fee assessed for that day's reschedule. Because we spend the time needed with each patient visit, we do run behind on occasion. In those situations, we would be happy to reschedule you upon request with no penalty.

Initial:_____ **Refills:** All refill requests will be addressed within 48 hours of receipt of a request form from the pharmacy. This allows time to review your chart notes and respond in an informed manner.

Initial:_____ **Labwork:** Please be aware of the laboratory that your insurance plan uses for blood and tissue samples. If you do not know, please contact your insurance plan and ask them. For your convenience, we can collect all lab specimens in our office. You services will be billed directly from the lab (Quest).

Initial:_____ **Urine Drug Screens:** Our office conducts mandatory urine drug screens on all patients who receive a medication that is labeled by the DEA as a scheduled medication. You are required to pay for the drug screen if it is not covered by insurance.

Initial:_____ **Paperwork Fees:** There is a $20 fee for any form of (1) page that requires a physician signature. If it is more than (1) page, the cost is $50.

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Service and Policies (continued)

Initial: _____ **Authorizations:** It is the goal of every staff member in this office to help facilitate the treatment of each patient. Insurance companies require authorization for procedures and medications. The insurance companies use authorizations as a way to control costs. Each company has different requirements and a separate set of medical necessity guidelines. It is impossible to know every company's policy for each medication and/or procedure. Our office provides the requested information to the insurance company but cannot dictate if it will be approved. Should you have an issue with something not being approved those concerns should be directed to the insurance company.

_____
Name (please print)

X_____ _____/_____/_____
Signature Date

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Patient Health Information Consent Form

We would like you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning your records. Before we can provide any health care we will require you to read and sign this consent form stating that you understand and agree on how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your health information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

I. I understand and agree to allow Total Care Family Practice to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. I agree to allow Total Care Family Practice to submit requested PHI to my health insurance company (or companies) provided to us by the patient for the purpose of payments. Please be advised that this office will limit the release of all PHI to the minimum.

II. I understand that I have the right to examine and obtain a copy of my own health care records.

III. I understand that this written consent is obtained every six months for all subsequent care given to me in this office.

IV. I understand that I have the right to request to revoke this consent at any time during my care.

V. For your security and rights to privacy, all staff of Total Care Family Practice has been trained in HIPAA regulations and records privacy to enforce those procedures in our office. We have taken all precautions to ensure you that your medical information will not be released to anyone.

VI. I understand that I have the right to file a formal complaint with our privacy officer about any possible violations of these policies and procedures.

VII. I understand if I refuse to sign this consent for the purpose of treatment, payment and health care services, our physicians have the right to refuse services.

In addition, I also give consent to Total Care Family Practice to disclose my protected healthcare information to the following person and/or people:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

I fully understand and accept the terms of this consent.

_____ _____
Patient's Name DOB

X_____ _____
Patient Signature Date

eMail form

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Balance Self- Test

1. Have you fallen in the past year? ☐ Yes ☐ No
2. Do you feel dizzy or off balance if you make a sudden change in movement, such as bending down or quickly turning? ☐ Yes ☐ No
3. Do you have any hearing loss? ☐ Yes ☐ No
4. Do you require assistance to walk, such as a Person supporting you, use a walker or a wheelchair? ☐ Yes ☐ No
5. Do you have balance problems when you are walking or climbing stairs? ☐ Yes ☐ No

Signature: _____

Patient Name: _____

Date: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to 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 figety 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	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. 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 _____

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ALCOHOL SCREENING FORM

Name: _____

Date of Birth: _____

Gender: _____

Date: _____

1. **Did you have a drink containing alcohol in the past year?**
    a. Yes
    b. No
2. **If 'YES': How often did you have a drink containing alcohol in the past year?**
    a. Never (0 point)
    b. Monthly or less (1 point)
    c. 2 to 4 times a month (2 points)
    d. 2 to 3 times a week (3 points)
    e. 4 or more times a week (4 points)
3. **If 'YES': How many drinks did you have on a typical day when you were drinking in the past year?**
    a. 1 or 2 drinks (0 point)
    b. 3 or 4 (1 point)
    c. 5 or 6 (2 points)
    d. 7 to 9 (3 points)
    e. 10 or more drinks (4 points)
4. **If 'YES': How often did you have 6 or more drinks on one occasion in the past year?**
    a. Never (0 point)
    b. Less than monthly (1 point)
    c. Monthly (2 points)
    d. Weekly (3 points)
    e. Daily or almost daily (4 points)
5. **Have you quit drinking alcohol and if so, when?** _____

PREVENTATIVE SCREENING FORM

- **Date of Last Colonoscopy:** _____
  - ☐ Normal
  - ☐ Abnormal

- **[FOR WOMEN] Date of Last Mammogram:** _____
  - ☐ Normal
  - ☐ Abnormal

- **[FOR WOMEN] Date of Last Pap Smear:** _____
  - ☐ Normal
  - ☐ Abnormal

- **[FOR MEN] Date of Last PSA Test:** _____

- **[FOR MEN] Date of Last Flu Shot:** _____

- **[FOR MEN] Date of Pneumovax (FOR PATIENTS 65 YEARS OF AGE & OLDER):** _____

- **[FOR MEN] Diabetic Eye Exam & Diabetic Foot Exam:** _____

Allergy Questionnaire - Part 3

To be filled out by patient during test development

ENVIRONMENTAL SURVEY

1. How long have you lived in your house/apartment? _____
2. Do you live in a ❑ House ❑ Apartment/duplex ❑ Condominium/townhouse
3. Approximately how old is your home? _____
4. Do you live in ❑ City ❑ Suburbs ❑ Rural area
5. Do you have a basement? ❑ Yes ❑ No
6. Type of heating: ❑ hot air ❑ steam (radiator) ❑ electric ❑ hot water (baseboard)
7. Do you have: ❑ Wood /coal stove or fireplace ❑ Humidifier ❑ Dehumidifier ❑ Air cleaner
8. Number of pets (indoor or outdoor) ____Cats ____Dogs ____Birds ____Other
9. Are there any tobacco smokers in your home? ❑ Yes ❑ No
10. Is your bedroom in the basement? ❑ Yes ❑ No
11. Do you have allergy-proof encasing for pillow or mattress? ❑ Yes ❑ No
12. What type of pillows do you have? _____
13. What type of comforter do you have? _____
14. What type of floor covering do you have in your bedroom? ❑ Wall to wall ❑ Area rug ❑ Animal skin ❑ Bare floor
15. How old is your mattress?_____ What's inside your mattress? (i.e. cotton/horse hair)_____
16. Do you have air conditioning? ❑ Yes ❑ No If yes, is it: ❑ Window unit ❑ Central
17. Do you have problems with roaches or mice? ❑ Yes ❑ No
18. Do you have water leaks, mold contamination? ❑ Yes ❑ No
19. Is your home/apartment excessively humid? ❑ Yes ❑ No
20. Do you experience runny nose or sneezing in response to eating? ❑ Yes ❑ No
21. Do you experience runny nose or sneezing in response to strong odors? ❑ Yes ❑ No
22. Do you experience runny nose or sneezing in response to exercise? ❑ Yes ❑ No
23. Do you experience runny nose in response to emotional upset? ❑ Yes ❑ No

MEDICAL HISTORY

1. Check all that apply:

❑ Diabetes	❑ Liver disease/hepatitis	❑ Peptic ulcer	❑ Heartburn/reflux
❑ Cancer	❑ Heart problems/murmur	❑ Thyroid disease	❑ Seizures
❑ High blood pressure	❑ Osteoporosis	❑ Arthritis	❑ Migraines
❑ Anemia/blood disorder	❑ Asthma	❑ Hay fever	❑ Depression
❑ Kidney/bladder disease	❑ Gynecological problems	❑ Diarrhea	❑ Anxiety
❑ Back problems	❑ Glaucoma	❑ Cataracts	❑ Loss of hearing
❑ Emphysema			

2. If yes to any of above, please explain: _____
3. Have you had your tonsils or adenoids removed? ❑ Yes ❑ No
4. Have you had ear, nose or sinus surgery? ❑ Yes ❑ No
5. If yes, please explain: _____
6. Who in your family has had: (NOT including yourself)
   ❑ Asthma _____ ❑ Eczema _____
   ❑ Seasonal /year round allergies _____ ❑ Sinus problems _____
   ❑ Other allergies (drugs/bee sting/food etc) _____
7. Do you smoke? ❑ Yes ❑ No If yes, how much?_____
8. Have you smoked in the past? ❑ Yes ❑ No How long ago did you stop? _____
9. How many years did you smoke? _____

Patient Name _____ Birthdate _____ Reviewed by _____ Date _____

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Allergy Questionnaire - Intake Questions

To Be Filled Out by Patient

Patient Name _____ Birthdate _____

Reviewed by _____ Date _____

1. Do you experience any of these symptoms more than twice per year? (Check all that apply)
   - ❑ Cough
   - ❑ Cold
   - ❑ Congestion
   - ❑ Difficulty breathing
   - ❑ Headaches
   - ❑ Wheezing
   - ❑ Runny nose
   - ❑ Sore throat
   - ❑ Itchy/irritated eyes
   - ❑ Sinus pain
   - ❑ Ear pain
   - ❑ Unexplained fatigue
   - ❑ Skin irritation
   - ❑ Snoring

2. Have you ever been diagnosed with asthma or bronchitis? ❑ Yes ❑ No

3. Do you experience symptoms of allergies? ❑ Yes ❑ No

4. Regarding possible food allergies, do you experience any of the following? (Check all that apply)
   - ❑ Bloating after eating
   - ❑ Diarrhea
   - ❑ Cough
   - ❑ Constipation
   - ❑ Upset stomach
   - ❑ Wheezing
   - ❑ Stomach pain
   - ❑ Indigestion
   - ❑ Nausea
   - ❑ Vomiting
   - ❑ Tingling of the mouth or any other unusual sensation

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Allergy Questionnaire - Part 2

To be filled out with allergy counselor after initial screening

1. What symptoms are you experiencing? (From #1 on intake form) _____

   _____

2. How often do you experience these symptoms? _____

3. Do you have any of these symptoms?

❑ Cough	❑ Runny Nose	❑ Nasal Polyps	❑ Eczema
❑ Wheezing	❑ Nasal Congestion	❑ Poor Sense of Smell	❑ Hives / Swelling
❑ Shortness of breath	❑ Itchy Nose	❑ Ear Infections	❑ Headaches
❑ Chest tightness	❑ Itchy / Watery Eyes	❑ Sinus Infections	❑ Snoring
❑ Sneezing	❑ Postnasal Drip	❑ Blocked Ears	❑ Fatigue
❑ Phlegm/sputum (Color_____)		❑ Other_____	

4. Which of the following seems to bother you or trigger/cause the above symptoms?

❑ Grass	❑ Cats	❑ Cosmetics	❑ Drafts
❑ Nervousness	❑ Hay	❑ Dogs	❑ Aerosol sprays
❑ House Dust	❑ Cold Air	❑ Mold & Mildew	❑ Horses
❑ Perfumes	❑ Smoke	❑ Humidity	❑ Basements
❑ Other Animals	❑ Insecticides	❑ Pollution	❑ Weather changes
❑ Leaves	❑ Alcoholic beverages	❑ Odors	❑ Exercise
❑ Latex (rubber)	❑ Insect bites/stings. Describe reaction: _____		
❑ Foods. List foods and reactions: _____			
❑ Other. List sources and reaction: _____			

5. When are your symptoms worst? ❑ Year round

❑ January	❑ February	❑ March	❑ April
❑ May	❑ June	❑ July	❑ August
❑ September	❑ October	❑ November	❑ December

6. Are symptoms better away from home? ❑ Yes ❑ No If yes, when? _____
7. Have you ever had an allergy skin test or blood test? ❑ Yes ❑ No If yes, results: _____
8. Have you ever had allergy injections? ❑ Yes ❑ No If yes, when? _____
9. Have you received cortisone (prednisone, methylprednisolone, etc.) drugs? ❑ Yes ❑ No
   If yes, when? _____ How much? _____
10. Are you on allergy medications? ❑ Yes ❑ No What meds? _____
    How much? _____ For how long? _____
11. What is your occupation? (current or former) _____

THIS SECTION FOR PROVIDER AND OFFICE USE ONLY

Is patient...

❑ Suffering from uncontrolled asthma ❑ History of anaphylaxis

If yes to above, refer out to specialist

❑ On beta blocker? ❑ Pregnant? ❑ Heavily tattooed?

❑ Significantly immunocompromised or have malignancy or severe chronic illness?

If yes to above, select blood test

Wheezing or having difficulty breathing?

Experiencing active hives or extensive dermatitis?

If yes to above, treat symptoms and schedule for another day

Having symptoms consistent with food allergies?

If yes to above, consider skin panel and food panel

Indications

Inhalant Panels: ❑ Skin Test ❑ Blood Test

Food Panels: ❑ Skin Test ❑ Blood Test

Schedule skin test for (Date): _____

Patient Name Birthdate Reviewed by Date

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