PATIENT INFORMATION FORM

PLEASE COMPLETE THE FOLLOWING INFORMATION

DATE_____ Please Print All Information

LAST NAME_____ FIRST NAME_____ MI_____

ADDRESS_____

CITY_____ ST_____ ZIP_____

PHONE_____ EMPLOYER_____

WORK PHONE_____

DATE OF BIRTH_____ AGE_____ SEX_____

SOC. SEC. # _____

SPOUSE NAME_____ DATE OF BIRTH_____

EMERGENCY CONTACT:

NAME:_____

RELATIONSHIP_____ PHONE_____

Pharmacy used:_____

REFERRING PHYSICIAN_____ PHONE_____

ADDRESS_____

SIGN_____ DATE_____

REASON FOR VISIT:_____

Medical Information Release Form

Name:_____ Date of Birth:_____/_____/_____

Release of Information

☐ I authorize the release of information including the diagnosis, records, examination rendered to me and claim information. This information may be released to:

☐ Spouse _____

☐ Children _____

☐ Other _____

☐ Information is not to be release to anyone

The release of Information will remain in effect until terminated by me in writing.

Messages

Please call: ☐ my home ☐ my work ☐ my cell Number:_____

If unable to reach me:

☐ You may leave a detailed message

☐ Please leave a message asking me to return your call

☐ _____

The best time to reach me is _____ between (time)_____

EMAIL:_____

Signed_____ Date_____

HEALTH QUESTIONAIRE

Patient Name_____ Date_____

1.) **List any allergies (i.e., drug, food, latex)**

Name- Explain type of reaction (rash, itching, swelling)

_____

_____

2.) **List all medications you are presently taking, including over-the-counter medications.**

_____

_____

3.) **Medical History:** **Circle all that apply to you.**

Heart Disease	Diabetic	Neurological Disorder
High Blood Pressure	Stroke	Arthritis
Chest Pain	Asthma	Psychiatric Disorders
Heart Attack	Bronchitis	Depression
Thyroid Disease	Heart Murmur	Emphysema
Glaucoma	Congestive Heart Failure	TB
Bleeding Disorders	Brain Damage	Mitral Valve Prolapse
Phlebitis	Sickle Cell Disease	Cerebral Palsy
Hypoglycemia	Hepatitis	Gastric Ulcers
Cancer	Skin Cancer	Dialysis
HIV/AIDS	Lupus	Kidney Problems
Seizure Disorders	MS	Melanoma
Pacemaker	Artificial Limbs or Joints	

OTHER:_____

4.) **List all previous surgeries:**

Approximate Year Type of Surgery

_____

_____

_____

_____

_____

5.) **Are you on any blood thinners (including aspirin)?** Yes _____ No_____

6.) **Do you faint or pass out?** Yes _____ No _____

7.) **Have you had any blood transfusions?** Yes _____ No _____

8.) **If female and being seen for acne or psoriasis; Date of last menstrual period:**

_____

9.) **If female and being seen for acne or psoriasis; Do you plan on becoming pregnant?**

Yes _____ No _____

Patient Name: _____ Date:_____

Hometown:_____

Color of Eyes:_____ Color of Hair:_____

How did you receive most of your sun damage? (ex. Farming, oil field, ect.) _____

_____

Is your sun damage, mild, moderate, or extreme? _____

Below is for nurse use only:

Actinic Keratosis:

Location(s):_____

Year(s) removed:_____

Doctor(s) and city where removed:_____

Family History: Yes or No Relationship:_____

Hypertrophic Actinic Keratosis:

Location(s):_____

Year(s) removed:_____

Doctor(s) and city where removed:_____

Family History: Yes or No Relationship:_____

Atypical Nevus:

Location(s):_____

Year(s) removed:_____

Doctor(s) and city where removed:_____

Family History: Yes or No Relationship:_____

Basal Cell Carcinoma:

Location(s):_____

Year(s) removed:_____

Doctor(s) and city where removed:_____

Family History: Yes or No Relationship:_____

Basosquamous Cell Carcinoma:

Location(s):_____

Year(s) removed:_____

Doctor(s) and city where removed:_____

Family History: Yes or No Relationship:_____

Squamous Cell Carcinoma:

Location(s):_____

Year(s) removed:_____

Doctor(s) and city where removed:_____

Family History: Yes or No Relationship:_____

Malignant Melanoma:

Location(s):_____

Year(s) removed:_____

Doctor(s) and city where removed:_____

Family History: Yes or No Relationship:_____

OTHER:_____

RELEASE OF INFORMATION

I hereby authorize Robert F. Bloom, M.D. to release to any person(s) any information they deem necessary for the collection of this account.

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of services rendered, I hereby transfer and assign Robert F. Bloom, M.D. all rights, title and interest in any payment due me for services described herein as provided in the policy or policies of insurance. I agree to pay Robert F. Bloom, M.D., the charges of said facility which exceed the amount paid by the insurance company or companies.

A photostatic copy of the authorization shall be considered as effective and valid as the original.

_____
Date

_____
Signature

THIS FORM ALLOWS ROBERT F. BLOOM, M.D. TO FILE YOUR INSURANCE AND COLLECT FROM YOUR INSURANCE COMPANY

NON-NETWORK PROVIDERS

I, _____ have been informed that my
(Patient's Name or Patient Representative)
Insurance company _____ is not in network with Robert
(Name of Insurance)
F. Bloom, M.D. I understand that I will have to pay for my full charged amount when I leave here today. If the total charges go over $150.00 today, I understand that my insurance will be filed and I will owe 20% today. I agree that I will be responsible for any remaining balance after the insurance pays out of network prices.

_____ _____
Patient Signature or Patient Representative Date

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Robert F. Bloom, M.D. to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operation (TPO). (Robert F. Bloom, M.D.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Robert F. Bloom, M.D. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Robert F. Bloom, M.D. Privacy Office at 1211 East 6th Street, Suite 150, Bonham, Texas 75418.

With this consent, Robert F. Bloom, M.D. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Robert F. Bloom, M.D. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Robert F. Bloom, M.D. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Robert F. Bloom, M.D.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Robert F. Bloom, M.D. may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____

Print Name of Patient or Legal Guardian

_____

Date

RECEIPT NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Robert F.
Print Patient Name
Bloom, M.D.'s Notice of Privacy Practices.

_____ _____
Signature of Patient or Legal Guardian Date