MRN: _____ Date: ____/____/____

Texas Health Care | PRIVIA MEDICAL GROUP

Physician: **DR. BLOEMENDAL** or **DR. BIRBARI**

Name: _____ Birthdate: ____/____/____ Age: _____ M F

Address: _____ City: _____ ST:_____ Zip: _____

Cell: _____ Day: _____ Last 4 of Social: _____

Email: _____ Marital Status: S M D W O

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino Race: _____ Language: _____

Primary Insurance: _____ Specialist Co-pay: _____

Member ID: _____ Group Number: _____

Policy Holder Name: _____ Birthdate: ____/____/____

Patient Relationship to Policyholder: ☐ Self ☐ Spouse ☐ Child Other: _____

Secondary Insurance: _____ Specialist Co-pay: _____

Member ID: _____ Group Number: _____

Policy Holder Name: _____ Birthdate: ____/____/____

Patient Relationship to Policyholder: ☐ Self ☐ Spouse ☐ Child Other: _____

Spouse's Name: _____ Cell: _____

Emergency Contact: _____ Cell: _____

Who referred you: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Employer: _____ Occupation: _____

Type of work (Physical Labor): Desk-Based Light Moderate Heavy or very heavy

Exercise Level: None Sporadic Moderate Intense

MRN: _____ Date: ____/____/____

Texas Health Care | PRIVIA MEDICAL GROUP

Physician: **DR. BLOEMENDAL** or **DR. BIRBARI**

Please read: This authorization allows our office to communicate with your insurance and patient responsibility.

Assignment of Benefits, Release of Information, Notice of Privacy Practices, Appointment of Authorized Representative

Texas Health Care, P.L.L.C. (THC), 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 THC has such a Notice of Privacy Practices. I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I, Hereby assign, transfer and set over to THC, 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 THC 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.

_____ _____

Signature of Patient or Personal Representative | Date

_____ _____

Printed Name of Patient or Personal Representative | Relationship

I consent and authorize your office or a facility on my behalf to conduct benefit verification services.

I hereby give my physician permission to discuss all diagnostic and treatment details with my other physicians and pharmacists regarding my use of medications prescribed by my other physicians.

_____ _____

Signature of Patient or Personal Representative | Date

_____ _____

Printed Name of Patient or Personal Representative | Relationship

Texas Health Care | PRIVIA MEDICAL GROUP

MRN: _____ Date: ____/____/____

Physician: **DR. BLOEMENDAL** or **DR. BIRBARI**

HIPAA Authorization for Release of Patient Health Information

In general, HIPAA (Health Insurance Portability and Accountability Act) gives patients the right to request the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means. This information will remain in effect until revoked in writing, except to the extent that action has already been taken.

I wish to be contacted in the following manner (check all that apply)

- ☐ Cell Phone
  - ☐ Ok to leave a detailed message
  - ☐ Leave call back number only
- ☐ Home Phone
  - ☐ Ok to leave a detailed message
  - ☐ Leave call back number only
- ☐ When unable to contact by phone, a written communication may be sent to my home address.
- ☐ Other: _____

I consent and authorize the release of NORMAL test results to the following:

- ☐ Only myself
- ☐ Other: _____ Relationship: _____
- ☐ Other: _____ Relationship: _____

I consent and authorize the release of ABNORMAL test results to the following:

- ☐ Only myself
- ☐ Other: _____ Relationship: _____
- ☐ Other: _____ Relationship: _____

Do you authorize our office, Dr. Bloemendal and Dr. Birbari to communicate with you by text message?

☐ Yes ☐ No

Do you have a Living will (advanced directive)? YES NO

_____ _____

Signature of Patient or Personal Representative | Date

_____ _____

Printed Name of Patient or Personal Representative | Relationship

Bloemendal Birbari — Patient History Form — MRN: _____

Texas Health Care/ Privia NTX

Today's Date: ____/____/____

Patient Name: _____ DOB: ____/____/____

Referred by: _____ Primary Care Dr: _____

***Pharmacy Name: _____ Phone #: _____

Address/ Cross Street: _____

Reason for visit (please circle): New Patient Post operative Follow up

Reason/ Symptoms:

_____

Current Medications/ OTC/ Vitamins- if you have a list, we can make a copy

_____

_____

_____

_____

_____

Medication Allergies (please circle) YES- see below NONE LATEX allergy

Please list medication names and reaction: _____

_____

Are you taking any blood thinners: YES (circle below) NO

Fish Oil Aspirin 81 Aspirin 325 Plavix Coumadin Eliquis Xarelto Brilinta Effient Pradaxa

Personal Medical History : Current and Past medical problems and diagnoses

☐ Heart Disease ☐ High Blood Pressure ☐ Asthma ☐ Diabetes ☐ COPD ☐ AFib

☐ Blood Disorder ☐ Cancer: _____ Other: _____

Surgical procedures:

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Name: _____ DOB: _____/_____/_____ MRN: _____

Please check the following symptoms you are **currently** having:

- ☐ Fever
- ☐ Fatigue
- ☐ Weight loss
- ☐ Difficult swallowing
- ☐ Sore Throat
- ☐ Cough
- ☐ Shortness of breath
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Ankle swelling
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Acid reflux
- ☐ Muscle weakness
- ☐ Joint pain
- ☐ Headache
- ☐ Dizziness
- ☐ Pain with urination
- ☐ Blood in urine
- ☐ Rash
- ☐ Itching
- ☐ Skin lesion or mass
- ☐ Depression
- ☐ Anxiety
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Easy bruising/bleeding
- ☐ Swollen lymph nodes

Current Physicians:

Cardiologist: _____

Pulmonologist: _____

Gastroenterologist: _____

Urologist: _____

(please circle)

Tobacco use: Cigarette Snuff Cigar Vape

How much per day: _____

Current: Age started: _____

Past: Age Quit: _____ Age started: _____

Never/ non tobacco user

(please circle)

Alcohol Use: Current Never/Rare Past

Type: _____ Amount per week: _____

Past: When did you quit? _____

Family History: Please list health conditions/illness (ex. Stroke, Heart Disease, Cancer)

Father: _____

Mother: _____

Sister: _____

Brother: _____

Grandparents: _____