Horizon Family Practice & Geriatrics
610 Strickland Dr. Suite 130
Orange, TX 77630
P: 409-330-4885 F: 409-330-4669

Please complete all the areas below if you are a new patient.
Please put your name and any changes if you are an established patient.

Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Gender: Male Female

Marital Status: Single Married Divorce Widowed

Race: White Black Asian Hispanic Other/Multi

Social Security #:___ - ___ - ___ Date of Birth:___/___/___

Home #:_____ Work #:_____

Cell #:_____ Employer:_____

Email:_____ Web Enable/Pt Portal Access: YES NO

Legal Guardian (if applicable):_____

Emergency contact - Name:_____

Phone #:_____ Relation:_____

Policy Holder Information

Insurance:_____ Member ID #:_____

Group #:_____ Policy Holder's Name:_____

Date of Birth:_____ Phone #:_____ SS#:_____

Address:_____

Employer:_____

Secondary Insurance Information

Insurance:_____

Address:_____

How did you hear about us? Existing Patient Physician Referral Friend/Relative Other

Patient Signature _____ Date_____

Patient Name:_____ DOB_____

Past Medical History

Circle all that YOU have or had in past, or write in any not mentioned

Heart/Blood Vessels: High Blood Pressure, Heart Attack, Heart Failure, Coronary Artery Blockage, Angina, TIA (Mini-Stroke), Congestive Heart Failure, Palpitations Heart, Stroke, Rhythm Problems (i.e. Atrial Fibrillation), Claudication, Heart Murmur, Pacemaker, Aneurysm

Lung/Respiratory: COPD/Emphysema, Bronchitis, Asthma, Pneumonia, Tuberculosis, Pulmonary Fibrosis, Pulmonary Hypertension, Asbestos exposure

Neurological (nerves/brain): Headaches - Migraine/Sinus/Tension/Other, Seizure disorder, Peripheral Neuropathy

Ear/Nose/Throat: Ear Infections, Nasal Polyps, Sinusitis, Chronic Nasal Congestion, Hearing loss, Nasal Allergies

Eye: Glaucoma, Eye Glasses/Contacts, Macular Degeneration, Iritis, Cataracts

Stomach/Liver/Intestines/Colon: Crohn's Disease, Colitis, Ulcerative Colitis, Hemorrhoids, Ulcers (stomach/duodenal), Reflux/GERD/Barrett's, Irritable Bowel Syndrome, Celiac Disease, Constipation, Milk (lactose) Intolerance, Diverticulosis, Diverticulitis, Hepatitis

Kidney/Urinary: Kidney Stones, Kidney Failure, Renal Insufficiency, Blood in Urine, Interstitial Cystitis, Urinary Tract Infection/UTI/Cystitis/Kidney Infection

Male Genital: Circumcision YES NO, Prostate Enlargement, Sexual Dysfunction

STD - Chlamydia Gonorrhea Herpes Genital Warts Syphilis HIV Hep B or C

Sexually Active YES NO NEVER *if yes* - Same partner Different partners

Patient Name:_____ DOB_____

Gynecologic (female reproductive):
Last Mammo _____
Breast lump/mass/cyst | Colposcopy | Abnormal Mammo
Pelvic Infection | Infertility | Last Pap _____
Ovarian cysts/Polycystic Ovarian Disease | Abnormal Pap
Pelvic Pain | Abnormal Cycles (irregular, heavy bleeding)
Sexual dysfunction
STD – Chlamydia Gonorrhea Herpes Genital Warts Syphilis HIV Hep B or C
Sexually Active: YES NO NEVER *if yes* – Same partner Different partners
Contraception Used: YES NO *If yes* – what kind –_____

OB: Ever Pregnant? YES NO
How many pregnancies?_____ Full term_____ Preterm_____
Miscarriages/Abortions_____ How many living children? _____
Vaginal Births # _____ C-Section # _____

Skin:
Acne | Eczema
Psoriasis | Keloids | Abnormal hair growth
Nail problems | Precancerous growths

Bone/Joint:
Low Back Pain | Neck Pain
Sciatica | Fracture(s) | Degenerative Arthritis
Plantar Fasciitis/Heel pain | Ankle Sprain

Blood/Bleeding:
Blood Clots/Pulmonary Embolus/Excess Clotting
Easy Bleeding | Easy Bruising

Endocrine (hormones):
Diabetes | Thyroid Dysfunction (Hypo/Hyper)
Thyroid Nodules | Graves' Disease | Cholesterol/Triglyceride problems

Rheumatology:
Rheumatoid Arthritis | Lupus
Sjogren's | Fibromyalgia | Chronic Fatigue

Mental Health:
Depression | Anxiety
Panic attacks | Post-Traumatic Stress Disorder (PTSD)
Bipolar Disorder | ADD/ADHD | Schizophrenia

Patient Name:_____ DOB_____

Cancer: _____ treatment received_____

_____ treatment received_____

Past Surgical/Procedure History (please date next to surgery) **None**

PET (ear Tubes)	Sinus Surgery	Tonsillectomy
Adenoidectomy	Cataract Surgery	Other Eye Surgery
Brain Surgery	CAB/CABG	Heart Stents
Heart Catheterization	Colon Removal	Gall Bladder Removal
Nissen Fundoplication (for GERD)		Hemorrhoid Surgery
Hernia Repair	Breast Surgery	Cosmetic Surgery
Appendectomy	Spleen Surgery	Kidney Surgery
TURP (prostate)	Vasectomy	Tubal Ligation
D&C (Dilation & Curettage)	Colposcopy	Cesarean Section
Laparoscopy	Ovary Surgery	Arthroscopy
Uterus Surgery (hysterectomy or other)		Spinal Fusion
Surgery for fracture _____		Diskectomy
Joint Replacement - Hip/Knee/Shoulder/other		Laminectomy

Other:_____

Preventive Health Screening (please give date):

Annual Labs_____ DEXA/Bone Density_____

Colonoscopy/Stool Test_____ Tetanus Booster_____

Pneumonia (Pneumovax23, Prevnar13)_____

Seasonal Influenza_____ Shingles(Zoster)_____

Exercise: Yes No Aerobics Resistance How often_____

Tobacco Use: Yes No Cigarettes Cigar Pipe Dip/Snuff

Amount per day_____ Interested in quitting? Yes No

Alcohol Use: Yes No Drinks per week_____

Illicit Drug Use: Yes No

Please list all Specialist(s) that you see:_____

_____

Please list past Hospitalizations:_____

_____

Patient Name:_____ DOB_____

Medication List

Allergies: **None**

_____ Type of Reaction_____

_____ Type of Reaction_____

_____ Type of Reaction_____

_____ Type of Reaction_____

Medication:	Strength:	Directions:	Reason Taking:	Prescriber:

Pharmacy Information:

Name:_____ Address:_____

Phone:_____ Fax:_____

For maintenance medications do you prefer 30 or 90 day supply? _____

Patient:_____DOB_____

Family History

(Circle any past or current medical conditions for the following family members)

Are you adopted? Yes or No

Father: Alive Deceased

HTN High Cholesterol Heart Disease Diabetes Cancer

Other:_____

Mother: Alive Deceased

HTN High Cholesterol Heart Disease Diabetes Cancer

Other:

Brother(s): Alive Deceased

HTN High Cholesterol Heart Disease Diabetes Cancer

Other:

Sister(s): Alive Deceased

HTN High Cholesterol Heart Disease Diabetes Cancer

Other:

Paternal Grandfather: Alive Deceased

HTN High Cholesterol Heart Disease Diabetes Cancer

Other:_____

Paternal Grandmother: Alive Deceased

HTN High Cholesterol Heart Disease Diabetes Cancer

Other:_____

Patient:_____DOB_____

Maternal Grandfather: Alive Deceased

HTN High Cholesterol Heart Disease Diabetes Cancer

Other:_____

Maternal Grandmother: Alive Deceased

HTN High Cholesterol Heart Disease Diabetes Cancer

Other:_____

Other Paternal Relatives:

Other Maternal Relatives:

HORIZON FAMILY PRACTICE & GERIATRICS

FINANCIAL POLICY

To help you with the costs associated with your care, we have developed the following financial policy. We want to make your visit with us a pleasant one. Please read and sign a copy of this before we provide any treatment.

INSURED PATIENTS:

We welcome all patients and many, but not all insurance plans. Please be aware that all insurance co-payments, deductibles, and non-covered charges need to be paid in full at the time of service. This will require that you present your current insurance card at each visit. If you present an expired card or inaccurate information, we will be unable to bill your insurance company, and you will be responsible for the total amount of the billed services. It is your responsibility to know your insurance plan. If you are in doubt as to whether a procedure, lab test, or radiological service is covered or if you are unsure as to where it must be performed, please call you plan's member service department prior to that service. Our office cannot be responsible for out-of-pocket expenses incurred as a result of utilizing the wrong provider, facility, or for having undergone non-covered tests or procedures. Even a verbal verification of benefits or coverage by your responsibility. Balances in excess of 60 days must be paid prior to any additional services being rendered.

UNINSURED PATIENTS:

We welcome our uninsured patients. Please know that payment in full is due at the time of service for all office visits and/or procedures, unless other arrangements have been made in advance. Self-pay patients with no balances on their account may be given a same day discount for all services paid in full at time of service. Some exclusions may apply. Patients failing to pay at time of service will be offered a lower discount.

DELINQUENT ACCOUNTS:

In the event that an account remains unpaid, delinquent accounts will be reported to Collection Management Services. This will result in a blemish on your credit report if unpaid.

Thank you for understanding our financial policy. Please let us know if you have questions or concerns. Your understanding of our financial policy is important to our professional relationship.

I have read and understand the Horizon Family Practice & Geriatrics Financial Policy. I understand that ultimately I am responsible for payment in full of any outstanding balances incurred during the course of my treatment.

Printed Name: _____

Signature: _____

Date: _____

HORIZON FAMILY PRACTICE & GERIATRICS

610 Strickland Dr. Suite 130, Orange TX, 77630
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ASSIGNMENT OF BENEFITS FORM

Date: _____

Patient's Name: _____

Employer: _____

Claim Group Name or #:_____

ID # or SS#: _____

I hereby instruct and direct _____ and (if applicable) _____
Insurance Company to pay my medical claims by check made out and mailed to:

Horizon Family Practice & Geriatrics
610 Strickland Dr. Suite 130
Orange, TX 77630

OR

If my current policy prohibits direct payment to provider, I hereby also instruct and direct you to make payment by assigning benefits directly to me and addressing payment to the temporary address as follows:

(Patient or Guarantor's Name)
c/o Horizon Family Practice & Geriatrics
610 Strickland Dr. Suite 130
Orange, TX 77630

For the professional or healthcare expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in current manner, any balances of said professional service charges over and above the insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at: _____(time) this _____ day of _____(month), 20___(year).

Signature (Patient/Guarantor/Policyholder): _____

Signature of Witness: _____

HORIZON FAMILY PRACTICE & GERIATRICS

MICCA RIEDEL, NP-C, GNP-BC
LAURA PITTMAN, NP-C
610 Strickland Drive, Suite 130
Orange, TX 77630
(409) 330-4885

GENERAL CONSENT FOR TREATMENT

I, knowing that I am suffering from a condition requiring diagnostic, medical, or surgical treatment do hereby voluntarily consent to such procedures and care and to such medical, surgical, or other services under the general and specific instructions of Horizon Family Practice & Geriatrics, their assistants or their designee as is necessary in their judgement.

I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatments or examination by Horizon Family Practice & Geriatrics, their assistants, or the designee.

Signature: _____ Date: _____

Horizon Family Practice & Geriatrics

Authorization to Disclose Information

I, _____, acting on behalf of _____
Patient or Legal Guardian — Self or Patient name

Hereby authorize the release of information as indicated below.

____ 1. I authorize disclosure of my personal healthcare information (related to my medical history, diagnosis, treatment and prognosis) to the following people:

Name_____Phone_____ Relationship_____

Name_____Phone _____Relationship_____

Name_____Phone _____Relationship_____

____ 2. I do not authorize the disclosure of any of my personal healthcare information.

I understand that I have the right to revoke this authorization at any time by signing and dating a new authorization.

Acknowledgement of Review of 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 upon request, I may receive a copy of this document.

_____ _____
Signature of Patient or Legal Guardian — Date

MEDICAL RECORD RELEASE FORM

By signing this form, I authorize _____ to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

HIV AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. Initial:_____ Date: _____

Please select the specific documents that apply:

- ☐ Clinic notes
- ☐ Progress notes
- ☐ H & P
- ☐ Discharge summary
- ☐ Radiology reports
- ☐ Lab reports
- ☐ Pathology reports
- ☐ Urgent care
- ☐ Nurses notes
- ☐ Operative reports
- ☐ EKG, EEG, EMG
- ☐ Other: _____
- ☐ Emergency room
- ☐ Specialist notes
- ☐ Physician orders

Release my protected health information to the following person(s)/entity:

HORIZON FAMILY PRACTICE & GERIATRICS
610 Strickland Drive, Suite 130
Orange, TX 77630
P: (409) 330-4885 F: (409) 330-4809

The reasons or purposes for this release of information are as follows:

_____

PRINT PATIENT NAME: _____D.O.B_____

PATIENT SIGNATURE (OR PARENT, GUARDIAN OR LEGAL REPRESENTATIVE):

_____

DATE: _____

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing this information may be charged according to rulings set for by the Texas State Board of Medical Examiners.