



# 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*

<b>Heart/Blood Vessels:</b>	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
<b>Lung/Respiratory:</b>	COPD/Emphysema	Bronchitis
Asthma	Pneumonia	Tuberculosis
Pulmonary Fibrosis	Pulmonary Hypertension	Asbestos exposure
<b>Neurological (nerves/brain):</b>	Headaches - Migraine/Sinus/Tension/Other	
Seizure disorder	Peripheral Neuropathy	
<b>Ear/Nose/Throat:</b>	Ear Infections	Nasal Polyps
Sinusitis	Chronic Nasal Congestion	Hearing loss
Nasal Allergies		
<b>Eye:</b>	Glaucoma	Eye Glasses/Contacts
Macular Degeneration	Iritis	Cataracts
<b>Stomach/Liver/Intestines/Colon:</b>		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
<b>Kidney/Urinary:</b>	Kidney Stones	Kidney Failure
Renal Insufficiency	Blood in Urine	Interstitial Cystitis
Urinary Tract Infection/UTI/Cystitis/Kidney Infection		
<b>Male Genital:</b>	Circumcision YES NO	Prostate Enlargement
Sexual Dysfunction		
STD - Chlamydia Gonorrhea Herpes Genital Warts	Syphilis	HIV Hep B or C
Sexually Active YES NO NEVER <i>if yes - Same partner</i>	Different partners	

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_

<b>Gynecologic (female reproductive):</b>		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 <i>if yes</i> - Same partner		Different partners
Contraception Used: YES   NO <i>if yes</i> - what kind - _____		
<b>OB:</b>	Ever Pregnant?   YES   NO	
How many pregnancies? _____	Full term _____	Preterm _____
Miscarriages/Abortions _____	How many living children? _____	
Vaginal Births # _____	C-Section # _____	
<b>Skin:</b>	Acne	Eczema
Psoriasis	Keloids	Abnormal hair growth
Nail problems	Precancerous growths	
<b>Bone/Joint:</b>	Low Back Pain	Neck Pain
Sciatica	Fracture(s)	Degenerative Arthritis
Plantar Fasciitis/Heel pain	Ankle Sprain	
<b>Blood/Bleeding:</b>	Blood Clots/Pulmonary Embolus/Excess Clotting	
Easy Bleeding	Easy Bruising	
<b>Endocrine (hormones):</b>	Diabetes	Thyroid Dysfunction (Hypo/Hyper)
Thyroid Nodules	Graves' Disease	Cholesterol/Triglyceride problems
<b>Rheumatology:</b>	Rheumatoid Arthritis	Lupus
Sjogren's	Fibromyalgia	Chronic Fatigue
<b>Mental Health:</b>	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: \_\_\_\_\_ DOB \_\_\_\_\_

### Family History

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

Are you adopted? Yes or No

<b>Father:</b>	Alive	Deceased			
HTN	High Cholesterol	Heart Disease	Diabetes	Cancer	
Other:	_____				
<b>Mother:</b>	Alive	Deceased			
HTN	High Cholesterol	Heart Disease	Diabetes	Cancer	
Other:	_____				
<b>Brother(s):</b>	Alive	Deceased			
HTN	High Cholesterol	Heart Disease	Diabetes	Cancer	
Other:	_____				
<b>Sister(s):</b>	Alive	Deceased			
HTN	High Cholesterol	Heart Disease	Diabetes	Cancer	
Other:	_____				
<b>Paternal Grandfather:</b>	Alive	Deceased			
HTN	High Cholesterol	Heart Disease	Diabetes	Cancer	
Other:	_____				
<b>Paternal Grandmother:</b>	Alive	Deceased			
HTN	High Cholesterol	Heart Disease	Diabetes	Cancer	
Other:	_____				

Patient: \_\_\_\_\_ DOB \_\_\_\_\_

<b>Maternal Grandfather:</b>	Alive	Deceased		
HTN	High Cholesterol	Heart Disease	Diabetes	Cancer
Other: _____				
<b>Maternal Grandmother:</b>	Alive	Deceased		
HTN	High Cholesterol	Heart Disease	Diabetes	Cancer
Other: _____				
<b>Other Paternal Relatives:</b>				
<b>Other Maternal Relatives:</b>				

# 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 your 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**

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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:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Clinic notes      | <input type="checkbox"/> Radiology reports | <input type="checkbox"/> Nurses notes      | <input type="checkbox"/> Emergency room   |
| <input type="checkbox"/> Progress notes    | <input type="checkbox"/> Lab reports       | <input type="checkbox"/> Operative reports | <input type="checkbox"/> Specialist notes |
| <input type="checkbox"/> H & P             | <input type="checkbox"/> Pathology reports | <input type="checkbox"/> EKG, EEG, EMG     | <input type="checkbox"/> Physician orders |
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Urgent care       | <input type="checkbox"/> Other: _____      |   |

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.