EVERCARE FAMILY CLINIC

Israel Valcarcel, APRN-FNP-C
1259 FM 1463 Suite 500
Katy, TX
P: (713) 429-5051
F: (713) 429-5786

PATIENT REGISTRATION INFORMATION

Date: _____

First Name: _____ Middle: _____ Last Name: _____ DOB: _____

Gender: _____ Marital Status: _____ Social Security#: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Work Phone: _____ Email: _____

Primary Language spoken: _____ Ethnicity: _____ Race: _____

Patient employer/school:_____ Occupation:_____

PHARMACY INFORMATION

Name:_____ Address:_____

Phone#: _____

Emergency Contact Name: _____ Relationship: _____ Phone # _____

Work Phone # _____ Address:_____

PRIMARY HEALTH INSURANCE INFORMATION

Policy Holder Name: _____ DOB:_____ SEX: _____

Phone#: _____ SS#:_____Insurance Policy Holder Relationship to patient: _____

Employer Name: _____ Name of Insurance:_____ ID/Policy#:_____

Group#:_____ Claims address:_____

Phone # for eligibility/ benefits:_____ Copay $:_____

SECONDARY HEALTH INSURANCE INFORMATION

Name of Insurance:_____ ID/Policy#:_____ Group#:_____

Claims address:_____

Phone # for eligibility/ benefits:_____ Copay $:_____

MEDICAL HISTORY

Previous or referring doctor: _____

Any specialist who currently takes care of you: _____ Phone#_____

_____ Phone#_____

MY AUTHORIZATIONS/RESPONSIBILITIES

Please initials each line

_____To assist us in filing insurance, I certify that the above information is correct. Deductible, co-payment, co-insurance, or non-covered services is my responsibility to pay and that I may asked for payment at the time of service. I understand that most insurance companies cover annual preventive services at 100% and that any additional medical services (e.g. prescriptions, referrals, detailed physical exams) are not part of the annual preventive visit.

_____To assign my insurance benefits to EverCare Family Clinic.

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_____To authorize my practitioners listed in my care plan to share information on my behalf for my care and for billing purposes.
_____To authorize the use of telemedicine in my care to the standards of the Texas Medical Practice Act.
_____That messages can be left on home or cell phone number provided above.
_____That I will identify with my insurance company that names of doctors to whom I will need referrals.
_____ That I will make the best effort to manage my care as defined in my care plan.
_____ Fees

- Missed appointments fee $25.00 unless cancelled 24 hours in advance.
- Returned checks will have a $35.00 service charge.
- Disability forms, special insurance forms $15.00 services charge.

_____All minor patients must be accompanied

** if you have any questions and/or concerns please ask one of our Costumers Service Representatives.

Nurse Practitioners Consent for Treatment

EverCare Family Clinic has staff Nurse Practitioners for the delivery of primary medical care with physician oversight. A Nurse Practitioner (NP) is a registered nurse who has completed either a master's or doctoral degree. They are trained in the diagnosis and treatment of common acute and chronic diseases, as wellness services. In addition, the NP can treat minor lacerations, and other minor injuries.

_____ I consent to the services of an NP for my visit and understand that I can request to see a physician after I have been seen by an NP.

Patient Signature/Authorized Signature for Patient: _____ Date: _____

ALL PROFESSIONAL FEES ARE DUE AT THE TIME OF SERVICE, UNLESS PREVIOUS ARRANGEMENT HAVE BEEN MADE.

FINANCIAL AGREEMENT

1. Services rendered to the patient, not the insurance company. As a courtesy, our office will file your insurance if proper information is received.
    a. You are responsible for copays, deductibles, non-covered services, co-insurance and items considered "not medically necessary" by your insurance company.
    b. For unpaid claims over 45 days, it is your responsibility to follow up with your insurance and the balance due is considered due and payable.
2. It is your responsibility to notify our front desk of any insurance or address change. You will be responsible for any changes that occur if we are not notified.

PATIENT AUTHORIZATION

I authorize EverCare Family Clinic to submit insurance claims using my signature on file bellow. I authorize the release of any medical information necessary in order to process this assignment on the claim. I authorize payment of medical benefits to be paid directly to EverCare Family Clinic PLLC.

_____ _____

Patient signature (or authorized representative) Date

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Name _____ Date _____

Review of Systems

General
- ☐ Chills
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Hair Loss
- ☐ Hair Growth-Excessive
- ☐ Night Sweats
- ☐ Sleeping Problems
- ☐ Thirst-Excessive
- ☐ Weight Gain
- ☐ Weight Loss

Mental Health
- ☐ Anxiety
- ☐ Depression
- ☐ Loss of Interest
- ☐ Feeling Hopeless
- ☐ Hearing Voices
- ☐ Marital Problems
- ☐ Panic Attacks
- ☐ Trouble Concentrating
- ☐ Suicide-Thoughts/Attempts

Skin
- ☐ Acne
- ☐ Bruise Easily
- ☐ Changes in Moles
- ☐ Chills
- ☐ Dry/Sensitive Skin
- ☐ Eczema
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars
- ☐ Sores That Won't Heal

Gastrointestinal
- ☐ Appetite Gain
- ☐ Appetite Loss
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Intestinal Disorder
- ☐ Lactose Intolerant
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

Genitourinary
- ☐ Blood in Urine
- ☐ Lack of Bladder Control
- ☐ Frequent Urination
- ☐ Painful Urination

Neurological
- ☐ Coordination Problems
- ☐ Convulsions
- ☐ Difficulty Walking
- ☐ Learning Disabilities
- ☐ Light-headedness
- ☐ Memory Loss
- ☐ Numbness/Tingling
- ☐ Paralysis
- ☐ Seizures
- ☐ Speech Problems
- ☐ Tremors

ENT
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earaches
- ☐ Ear Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Hearing Loss
- ☐ Nose-Bleeds
- ☐ Persistent Cough
- ☐ Persistent Runny Nose
- ☐ Recurring Sore Throat
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Vision Halos

Respiratory
- ☐ Coughing
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Wheezing

Cardiovascular
- ☐ Chest Pains
- ☐ Irregular Heart Beat
- ☐ Circulation Problems
- ☐ Heart Palpitations
- ☐ Rapid Heart Beat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

Musculoskeletal
- ☐ Back Pain
- ☐ Carpal Tunnel Syndrome
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Neck Pain
- ☐ Shoulder Pain

Women Only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between Periods
- ☐ Breast Lump
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Vaginal Discharge
- ☐ Urinating During the Night

_____ # of Pregnancies
_____ # of Miscarriages
_____ # of Abortions
_____ # of Living Children

What birth control method? _____

Men Only
- ☐ Erection Difficulties
- ☐ Ejaculation Difficulties
- ☐ Lump in Testicles
- ☐ Pain/Swelling in Testicles
- ☐ Penile Discharge
- ☐ Sore on Penis
- ☐ Urinating During the Night

Health Exams & Procedures

Please check and date the last time you had each exam or procedure done.

	Month & Year
☐ Cholesterol Test	_____
☐ Colonoscopy	_____
☐ CT/CAT Scan	_____
☐ EKG	_____
☐ MRI	_____
☐ Physical Exam	_____
☐ Stress Test	_____
☐ Ultrasound	_____

Women Only

	Month & Year
☐ Pap Smear	_____
☐ Mammogram	_____
☐ Bone Density	_____

Immunizations

Please check and date all immunizations you have had.

	Month & Year
☐ Hepatitis A	_____
☐ Hepatitis B	_____
☐ Influenza	_____
☐ Pneumonia	_____
☐ Polio	_____
☐ Tetanus	_____
☐ TDAP	_____

Men Only

	Month & Year
☐ Prostate Exam	_____
☐ Rectal Exam	_____
☐ PSA Screening	_____

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Did you have a drink containing alcohol in the past year?

- ☐ Yes
- ☐ No

If 'Yes': How often did you have a drink containing alcohol in the past year?

- ☐ Never (0 points)
- ☐ Monthly or less (1 point)
- ☐ Two to Four times a month (2 points)
- ☐ Two to Three times a week (3 points)
- ☐ Four or more times a week (4 points)

If 'Yes': How many drinks did you have on a typical day when you were drinking in the past year?

- ☐ 1 or 2 (0 points)
- ☐ 3 or 4 (1 point)
- ☐ 5 or 6 (2 points)
- ☐ 7 to 9 (3 points)
- ☐ 10 or more (4 points)

If 'Yes': How often did you have 6 or more drinks on one occasion in the past year?

- ☐ Never (0 points)
- ☐ Less than monthly (1 point)
- ☐ Monthly (2 points)
- ☐ Weekly (3 points)
- ☐ Daily or almost daily (4 points)

Total Points: ____

Interpretation

- ☐ Positive
- ☐ Negative

Interpretation

The AUDIT-C is scored on a scale of 0-12 (scores of 0 reflect no alcohol use)

- In men, a score of 4 or more is considered positive
- In women, a score of 3 ore more is considered positive

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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 "X" to indicate your answer)

	Not at All	Several Days	More Than Half the Days	Nearly Every Day
	0	1	2	3
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down. Depressed or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7.Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

Total Score: ☐

Interpretation

- ☐ Minimal Depression
- ☐ Mild Depression
- ☐ Moderate Depression
- ☐ Moderately Severe Depression
- ☐ Severe Depression

Interpretation of Total Score for Depression Severity

- 1-4 Minimal Depression
- 5-9 Mild Depression
- 10-14 Moderate Depression
- 15-19 Moderately Severe Depression
- 20-27 Severe Depression

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, DOB: _____, SS#: _____

Hereby authorize and consent to allow: _____
Previous Physician's Name

_____
Physician's Address and/or Phone Number

to disclose information contained in, provide access to, or provide such photocopies as may be reprinted for any Protected Health/ Billing information to the person or organization listed below:

Israel Valcarcel, APRN-FNP-C

1259 FM 1463 Suite 500

Katy, TX 77494 or to FAX 713.429.5786

The specific information to be used or disclosed is:

_____ All Records
_____ All Records between the dates of _____ and _____
_____ All Records pertaining to _____ medical condition only

I hereby release covered entity and its staff from all legal responsibility or liability, which may arise from the release of or reproduction of such Protected Health/Billing Information to the recipient. I understand my Protected Health /Billing Information that is used or disclosed by this authorization may be subject to redisclosure by the recipient and the law will no longer protect the privacy of my Protected Information. The patient must sign this authorization If the patient is a minor or is an incompetent adult their legal guardian must sign this authorization. If there is no guardian appointed by the courts the authorization must be signed by the nearest relative. If the patient is unable to sign this authorization, please state the reason: _____

This consent and authorization may include, but is not limited to the release of psychological, psychiatric, alcohol, drug abuse and HIV/AIDS information.

_____ _____
Signature of Patient/Legal Guardian Date

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Name _____ Date _____

Reason for visit

What brings you to the office today?

How is your general health?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any other concerns you would like to address?

Past Medical History

☐ Alcoholism	☐ Blood Transfusion	☐ Heart Disease/Problems	☐ Osteoporosis
☐ Allergies	☐ Cancer/Type: _____	☐ Hepatitis A,B or C	☐ Pneumonia
☐ Anemia	☐ Diabetes	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Anxiety Disorder	☐ Depression	☐ High Cholesterol	☐ Sexually Transmitted Diseases
☐ Arthritis	☐ Ear Problems	☐ Joint Disorder	☐ Skin Disorder
☐ Asthma	☐ Eating Disorder	☐ Kidney Disorder	☐ Stomach Ulcer
☐ AIDS/HIV	☐ Epilepsy	☐ Liver Disorder	☐ Stroke
☐ Back Problems	☐ Glaucoma	☐ Lung Disease	☐ Substance Abuse
☐ Bleeding Disorder	☐ Gout	☐ Measles	☐ Thyroid Disorder
☐ Blood Disease	☐ Heart Attack (MI)	☐ Migraines	☐ Tuberculosis

Hospitalizations & Surgeries

Date _____ Reason _____

Date _____ Reason _____

Date _____ Reason _____

Family History

Has anyone in your family ever had any of the following conditions? Please indicate which family member.

☐ Alcoholism _____	☐ AIDS/HIV _____	☐ Glaucoma _____	☐ Liver Disorder _____
☐ Allergies _____	☐ Bleeding Disorder _____	☐ Heart Disease _____	☐ Lung Disease _____
☐ Alzheimer's _____	☐ Blood Disease _____	☐ Hepatitis _____	☐ Migraines _____
☐ Anemia _____	☐ Cancer _____	☐ High Blood Pressure _____	☐ Psychiatric Disorder _____
☐ Anxiety Disorder _____	☐ Diabetes _____	☐ High Cholesterol _____	☐ Osteoporosis _____
☐ Arthritis _____	☐ Epilepsy _____	☐ Joint Disorder _____	☐ Stroke _____
☐ Asthma _____	☐ Genetic Disorder _____	☐ Kidney Disorder _____	☐ Substance Abuse _____
			☐ Thyroid Disorder _____

Lifestyle Factors

Are you sexually active? ☐ Yes ☐ No # of partners in past year _____

Do you wish to be checked for STD's? ☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you? ☐ Yes ☐ No

Have you ever smoked? ☐ Yes ☐ No # of years _____

Do you smoke now? ☐ Yes ☐ No # packs/day _____

Do you use recreational drugs? ☐ Yes ☐ No

How much alcohol do you drink per week? # drinks/week _____

How much caffeine do you drink daily? # drinks/day _____

How often do you exercise? # times/week _____

Medications

Please list all medications with dosage and frequency

Allergies