Premier Family Medicine
Offices of Dr. Miguel E. Trevino MD, PA
and Dr. Timothy L. Light DO

Date:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

How did you hear about us?	
Name: *(Last, First, M.)*	**Male** □ **Female** □
Social Security #:	**DOB:**
Address: *(Street, Apt/Lot#)*	
(City, State, Zip)	
E-mail:	
Telephone: *Home* *Work* *Cell*	
Occupation:	
Marital Status: □ Single □ Partnered □ Married □ Separated □ Divorced □ Widowed	
Preferred Pharmacy:	**Phone #:**
Pharmacy address:	
Emergency Contact:	**Relationship:**
Emergency Contact Phone #:	
INSURANCE INFORMATION	
Name of Insurance CO #1	
Insurance Address	
Policy Holder's Name *(if different from patient)*	
Policy holder D.O.B	
Policy #	**Group #**
Name of Insurance CO #2	
Insurance Address	
Policy Holder's Name *(if different from patient)*	
Policy holder D.O.B	
Policy #	**Group #**

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician of medical benefits. If benefits are otherwise payable to me for services rendered, I realize I am responsible to pay non-covered services, co-pays, co-insurance amounts and or deductibles.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment to process insurance claims.

PATIENT SIGNATURE **DATE**

What is the main reason for your visit today?

What previous treatment have you had for this problem?

IMMUNIZATION/ILLNESS/HOSPITALIZATION HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and Dates:			
	☐ Hepatitis A	☐ Gardasil	☐ Pneumonia
	☐ Hepatitis B	☐ Tetanus	☐ Chickenpox
	☐ Influenza	☐ Shingles Vaccine	☐ MMR

Surgeries/Hospitalizations

Year:	Reason:	Hospital:

MEDICAL ILLNESSES/CONDITIONS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain and include date of onset

	DATE:		DATE:		DATE:
☐ Anemia		☐ Hay Fever, Allergies		☐ Shingles pain	
☐ Angina		☐ Heartburn		☐ Skin Problems	
☐ Arthritis		☐ Heart Attack		☐ Stroke	
☐ Asthma		☐ Heart Murmur		☐ Swallowing trouble	
☐ Bleeding Trouble		☐ Hemorrhoids		☐ Syphilis	
☐ Blindness		☐ Hernia		☐ Thyroid	
☐ Bowel Trouble		☐ Hepatitis		☐ Tuberculosis	
☐ Broken Bones		☐ Herpes – Type:		☐ Ulcers	
☐ Cancer		☐ High Blood Pressure		☐ Urinary Trouble	
☐ Cataracts		☐ High Cholesterol		☐ Varicose veins	
☐ Chicken Pox		☐ High Triglycerides			
☐ Chlamydia		☐ HIV		**Men**	
☐ Chronic Bronchitis		☐ Kidney Disease		☐ Prostate trouble	
☐ Cirrhosis		☐ Kidney Stones			
☐ Cold Sores/ Fever Blisters		☐ Low Blood Sodium		**Women**	
☐ Constipation		☐ Measles		Age at start of menstruation:	
☐ Deafness/Hearing Trouble		☐ Migraine Headaches		First day of last menstrual cycle:	
☐ Depression		☐ Mumps			
☐ Diabetes		☐ Neuropathy		Method of birth control:	
☐ Dysentery		☐ Osteoporosis			
☐ Emotional		☐ Pain – Where:		# of live births	
☐ Emphysema		☐ Phlebitis		# of pregnancies	
☐ Enlarged Heart		☐ POTS/Dysautonomia		☐ Menstrual problem(s)	
☐ Erectile Dysfunction		☐ Recurrent boils		☐ Abnormal PAP	
☐ Gastric Reflux		☐ Recurrent Ear Infections		☐ Ovarian cyst(s)	
☐ Glaucoma		☐ Recurrent Sinusitis		☐ Breast Lump(s)	
☐ Goiter		☐ Rectal Trouble		Are you menopausal **Y** **N**	
☐ Gonorrhea		☐ Rheumatic Fever		If yes, when did this start:	
☐ Gout		☐ Seizures/Convulsions			

☐**Attach your own list of medications or complete the following medication history section**

MEDICATION HISTORY List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers			
Name of Drug	**Strength**	**Frequency Taken**	**Start Date**

ALLERGIES TO MEDICATION	
Name of Drug	**Reactions You Had**

List any medical problems that other doctors have diagnosed and dates *(not already listed)*:

Health Maintenance Please provide most recent dates with corresponding procedure	
Procedure:	**Date:**
Chest X-ray	
Colonoscopy	
DEXA Scan	
Mammogram	
Pap smear	
Physical Exam	

DIRECT FAMILY HEALTH HISTORY

(Mother/Father/Sister/Brother - Check all that apply and list family relation)

☐ **Check if N/A – adopted or unknown**

☐ Cancer/Type: Age of Onset:	☐ Hypertension: Age of Onset:
☐ Diabetes: Age of Onset:	☐ Stroke: Age of Onset:
☐ Heart Disease: Age of Onset:	☐ Other: Age of Onset:

HEALTH HABITS AND PERSONAL SAFETY

All questions contained in this questionnaire are optional and will be kept strictly confidential

Exercise	☐ No exercise ☐ Mild ☐ Occasional vigorous exercise ☐ Regular vigorous exercise (more than 3x/wk) Type:
Diet	Are you on a special diet? ☐ YES ☐ NO
	If yes, what kind?
Caffeine	☐ None ☐ Coffee ☐ Tea ☐ Cola
	# of cups/cans per day?
Alcohol	Do you drink alcohol? ☐ YES ☐ NO
	If yes, how many drinks per week?
Tobacco	Do you use tobacco? ☐ YES ☐ NO
	☐ Former smoker, quit date? # of years:
	☐ Cigarettes – pks/day ☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day
Drugs	Do you currently use recreational or street drugs? ☐ YES ☐ NO
	If yes, please list:
	Have you ever given yourself street drugs with a needle? ☐ YES ☐ NO
Sex	Are you sexually active? ☐ YES ☐ NO
	If yes, are you sexually active with: ☐ Men ☐ Women ☐ Both
	Sexually transmitted diseases and illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, have become a major public health problem. Risk factors for these illnesses include intravenous drugs use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of these illnesses? ☐ YES ☐ NO

Patient Signature **Date**

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, Dr. Miguel E. Trevino MD, PA as well as Dr. Timothy L. Light, DO originate and maintain health records describing my health history, symptoms, examination and test results diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

I understand that I can give my permission to have my medial history and current medical file(s) reviewed by Dr. Miguel E. Trevino MD, PA, Dr. Timothy L. Light, DO, and Innovative Research Staff, in order to evaluate if I am a possible candidate for any of their research studies; and thereby eligible for all medications, health supervision and visits, in this office, and in some cases financial recompense for my participation, if I should qualify for a study and choose to participate.

_______ Accepted ________ Denied

****I would also like to <u>allow</u> the following individuals to have access to my Confidential Health Information that I have listed below (ex. Mother/Father's Legal name, Husband/Spouse legeal name, Daughter/ Son's legal name):**

____

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____ ______________________

Signature of Patient or Legal Representative Date

OR

I request the following restrictions to the use or disclosure of my health information:

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____ ______________________

Signature of Patient or Legal Representative Date

FINANCIAL POLICY

As your physician, we are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance and understanding of our payment policy.

PAYMENT FOR SERVICE IS DUE AT THE TIME SERVICES ARE RENDERED – We accept cash, personal checks, MasterCard and Visa. Returned checks are subject to a service charge of $20.00 or 5% of the face values of the check, whichever is greater, and you will lose your privilege to write checks in our office.

CANCELED APPOINTMENTS – Patients who do not give 24 hours' notice for cancellation of an appointment will be charged a **$50** no-show fee. Patients who do not cancel appointments within 24 hours may be discharged from the practice after the third no-show.

BLUE CROSS/BLUE SHIELD PPO/HMO/MANAGED CARE COVERAGE – CO-PAYMENT AND DEDUCTIBLE MUST BE PAID AT THE TIME OF SERVICE. Because we are under contract with these insurance companies, we will file your insurance.

MEDICARE – Your deductible and 20% of the allowable charges are due at the time of service. Since we are a Medicare provider we will file your Medicare. If we do not know the Medicare allowable charge for a specific service, we will bill you after Medicare pays. Please bring your Medicare Explanation of Benefits (EOB) showing you have met your deductible.

FINANCIAL AGREEMENT – We will gladly discuss proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however, that:

1. **Your Insurance is a contract between you, your employer, and the Insurance Company. We are not a party to that contract.**
2. **Not all services are a covered benefit in all contracts. Some Insurance companies arbitrarily select certain services they will not cover (eg, yearly physicals).**

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.** On any balance on your account after 90 days, including those that insurance had not paid, collection action will be taken. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases occur, please contact us promptly for assistance in the management of your account.

If it becomes necessary to collect any sum due through an attorney, then the patient agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I have read and understand the above Financial Policy.

_______________________________________ _______________________

Signature **Date**

NOTICE OF INFORMATION PRACTICES

1. MIGUEL E. TREVINO, MD, PA, as well as TIMOTHY L. LIGHT, DO may use and disclose protected health information for treatment, Payment and healthcare operations. Examples of these include, but are not limited to, requested pre-school, life insurance, or sports physicals, referral to nursing homes, foster care homes, home health agencies and/or referral to insurance companies for claims including coordination of benefits with other insurers; and collection agencies. Healthcare operations include, but are not limited to, internal quality control and assurance including auditing of records.
2. MIGUEL E. TREVINO, MD, PA, as well as TIMOTHY L. LIGHT, DO is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health requirements or court orders.
3. MIGUEL E. TREVINO, MD, PA, as well as TIMOTHY L. LIGHT, DO will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorizations may be revoked at any time. Revocation must be written.
4. MIGUEL E. TREVINO, MD, PA, as well as TIMOTHY L. LIGHT, DO may at times contact the patient to provide appointment reminders or information regarding treatment alternatives or other health related benefits and services that may be of interest to the individual.
5. MIGUEL E. TREVINO, MD, PA, as well as TIMOTHY L. LIGHT, DO will abide by the terms of this notice of the notice currently in effect at the time of the disclosure.
6. MIGUEL E. TREVINO, MD, PA, as well as TIMOTHY L. LIGHT, DO reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information of the patient. Copies may also be obtained at any time at our office.
7. MIGUEL E. TREVINO, MD, PA, as well as TIMOTHY L. LIGHT, DO will provide each patient with a copy of any revisions of its Notice of Information Practice at the time of their next visit, or at their last known address if there is a need to use or disclose any protected information of the patient. Copies may be obtained at our office any time.
8. MIGUEL E. TREVINO, MD, PA, as well as TIMOTHY L. LIGHT, DO Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their rights have been violated. To file a complaint with the practice, please contact the Privacy Office at the following address and/or phone number: (1573 South Fort Harrison Avenue, Clearwater, FL 33756, Phone (727) 584-8777). All complaints will be addressed and the results will be reported to the Corporate Compliance Officer.
9. MIGUEL E. TREVINO, MD, PA, and TIMOTHY L. LIGHT, DO The title and telephone number of a person in the office to contact for further information is the Office Manager at (727) 584-8777 ext 209.
10. The effective date of this Notice of December 1, 2002.

You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of TIMOTHY L. LIGHT, DO/Dr. Miguel E. Trevino MD, PA We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services, Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202)619-0257 or Toll Free: 1-877-696-6775