Alma Lemez, M.D.
6955 N Mesa St Suite .302C
El Paso, Texas 79912
Phone 915-500-4307 Fax 915-500-4668

Patient Information Form

General Information

Patients Name:_____ DOB:_____ Sex:_____
Mailing Address:_____ SS#:_____
City/State/Zip Code_____ Home Phone:( )_____
E-Mail Address:_____ Cell Phone:( )_____
Patients Employer:_____ Work Phone:( )_____
Employer Address:_____

Spouse/Guardian
Name:_____ DOB:_____
SS#_____ Work Phone ( )_____ Cell Phone ( )_____

In Case of Emergency Contact_____ Phone( )_____

Pharmacy Information

What pharmacy would you like your prescription sent to?
Name:_____
Address:_____ City/State/Zip_____
Phone:_____

Primary Insurance Information

1st Insurance:_____
Policy #:_____ GRP#:_____
Address:_____
City/State/Zip Code:_____
Subscriber:_____ Relationship to Subscriber_____
Subscriber DOB:_____ Subscriber SS#_____

Secondary Insurance Information

1st Insurance:_____
Policy #:_____ GRP#:_____
Address:_____
City/State/Zip Code:_____
Subscriber:_____ Relationship to Subscriber_____
Subscriber DOB:_____ Subscriber SS#_____

Insurance Authorization and Assignment
I authorize Alma Lemez, M.D. to my insurance carrier and/or her staff any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to Alma Lemez, M.D. I understand that I am ultimately responsible for all services whether covered by insurance or not.

Signature:_____ Date_____

Patient History Form

WE STRIVE TO KEEP ALL INFORMATION IN CONFIDENCE AND WILL NOT RELEASE WITHOUT SIGNED CONSENT. It may be sent to consultants, if referred. DATE TODAY:_____.

NAME:_____ Birth date: _____ AGE: _____
LAST FIRST M.I.

MARITAL STATUS: ( ) SINGLE; ( ) MARRIED; ( ) WIDOWED; ( ) SEPARATED; ( ) DIVORCED
OCCUPATION:

REASON FOR VISIT Today:

LAST MEDICAL EXAM:
LAST DOCTOR:
LAST CHEST X-RAY (Date and location)

ALLERGIES (DRUGS, X-RAY DYE, TAPE, LATEX)/ & type of reaction:

PHARMACY NAME &#: _____ "Have available for calls that may require meds".

MEDICATIONS: (LIST ALL INCLUDING ONES NOT PRESCRIBED. such as alternative agents or herbal agents).

DRUG	STRENGTH	HOW OFTEN YOU TAKE PER DAY	LENGTH OF TIME YOU HAVE TAKEN
i.e. Advil	200 mg.	3 times per day	6 months

Please know what drugs and doses you take; if you need refills let the nurse know whe she places you in the exam room.

CHILDHOOD ILLNESSES: Chicken Pox ( ). Measles/Rubeola ( ). Mumps ( ). Rubella ( ). Scarlet fever ( ).

PREVIOUS MEDICAL ILLNESS/HOSPITALIZATION (other than under surgery):

*If Diabetic, do you self-test with glucose meter?_____; do you get yearly eye exams?____;have you been to a self-management course?____; do you know what to do for low blood sugar?____; foot care?____; HgbA1C current value?

SURGERY: (IF YES, PLEASE CHECK (X) AND GIVE APPROXIMATE DATE IN BLANK SPACE)

( ) Appendectomy_____ ( ) C-Sections_____ ( ) Hernia repair_____
( ) Breast Biopsy_____ ( ) Gallbladder_____ ( ) Hysterectomy_____ ( ) Ovary R L_____
( ) Carotid artery_____ ( ) Heart angioplasty_____ ( ) Mastectomy_____ ( ) Stomach surgery_____
( ) Cataracts_____ ( ) Heart bypass_____ ( ) Prostate removal_____ ( ) Tonsillectomy_____
Other surgery not listed:

OB/GYN History: Pregnancies: #_____. Deliveries: #_____. Last menstrual cycle:_____

**Check ____ if YES or Write NO, infront of items that follow below.

____Tobacco Use currently? ____# of packs per day:_____; # of years:_____
Are you interested in stopping? (Y____) (N____)
____Tobacco Use in past? When did you stop?
If you continue to smoke, exercise regularly! When ready to stop, call if you want help.
____Alcohol Use? Beer____; Wine____; Mixed Liquor:____. Oz (or glasses or cans per week average):____
*** Do not mix drinking and driving please. ***
____Caffeine Use? Coffee cups per day: Sodas per day:

____Exercise regularly? Type:_____; Times per week:_____
*** Goal of 30 minutes of walking-type exercise 5 days per week recommended. ***

Patient History Form

DATE_____.

NAME:_____.

Last First M.I. Date of Birth

FAMILY HISTORY: Check the box (X) next to the condition that your family member has; then specify their relation to you after the disease, using the abbreviations as follows:
Mother (M), Father (F), Brother (B), Sister (S), Grandparent (GP), Aunt (A), Uncle (U)
For example, if your Aunt and Mother had breast cancer (X) *BREAST CANCER A,M*

( ) Alcoholism	( ) Colon Polyps	( ) High Blood Pressure	( ) Prostate cancer
( ) Anemia	( ) Colon cancer	( ) Iron Disease	( ) Seizures
( ) Asthma	( ) Diabetes	( ) Kidney Disease	( ) Thyroid disease
( ) Arthritis	( ) Glaucoma	( ) Mental Illness	( ) Tuberculosis
( ) Bleed easily	( ) Gout	( ) Migraine	
( ) Breast Cancer	( ) Heart Disease	( ) Osteoporosis	

	LIVING	AGE OR AGE AT DEATH.	Present health or cause of death
FATHER	( ) Yes, ( ) No	_____	_____
MOTHER	( ) Yes, ( ) No	_____	_____
SIBLINGS			

Immunizations: (Please check the disease against which you have been immunized and date of last booster.) **"Tetanus or Td booster is due every 10 years."** Let the nurse know if you are due for a booster.

( ) Hepatitis B_____; ( ) Tetanus_____; ( ) Measles/Mumps/Rubella_____
( ) D.T. (Diphtheria/Tetanus)_____;
( ) Pneumonia_____; ( ) Hepatitis A _____; ( ) Flu vaccine_____;
( ) Varicella _____; ( ) Meningitis vaccine _____;

***If you have Hepatitis C or chronic liver disease, talk to your doctor about keeping up to date with your shots. You may benefit from Hepatitis A or B vaccine, or even the Pneumonia shot.
***If you have lung disease, keep up to date with the Influenza and Pneumonia shots.

Illicit Drugs Use? Please discuss with your physician.

Risk factors for AIDS & Hepatitis B and C are the following. If any apply, please let your physician know during your visit. We will observe confidentiality.
Blood transfusion; Homosexual relations; IV Drug use; Relations with IV Drug user; Needle Sticks; Work with body fluids, such as dental work, nursing, ER, etc., or Sex with multiple partners.

Check_____If YES or Write NO, for items that follow.

_____**Diet:** Are you interested in information on diets for weight or cholesterol or diabetes?
_____**Calcium intake:** Do you know women need about 1000mg. of calcium intake per day?
_____**Bone Density tests:** check if interested in information; considered after age 50 in women.
_____**Colon exams:** Did you know most experts recommend a colon exam every 5 years, after age 50? Please let us know if you have a family history of colon cancer.
_____**Mammography:** recommended yearly in women after age 40; check if due for this test.

Safety Measures: Examples of action you can take are: Seat belts (every time), bicycle helmets (even adults), wrist protection during roller-blading, eye protection (weed-eating, power sawing, etc.), proper gun use (locking, unloading, keeping out of children's access).

Advanced Directives: **Please discuss with your spouse or family and your physician.**
Living Will? No ( ); Yes ( ). Organ Donor? No ( ) Yes ( );
Durable Power of Attorney for Health Care? No ( ); Yes ( ). Who?

Patient History Form

NAME _____

LAST NAME FIRST NAME DOB/MM/YY DATE

PLEASE PLACE A Y BY THE CURRENT COMPLAINT OR ALIMENT THAT APPLIES TO YOU. IF UNSURE, PLACE A QUESTION MARK (?) IF IT DOES NOT APPLY, PLACE AN N.

HEAD
____ BLURRED VISION
____ LAST EYE EXAM DATE
____ GLAUCOMA
____ FREQUENT HEADACHES
____ MIGRAINE HEADACHES
____ LUMPS OR SWELLING IN NECK
____ CONSTANT RINGING IN EARS
____ HEARING PROBLEMS
____ FREQUENT EARACHES
____ FREQUENT NOSEBLEEDS
____ SINUS INFECTION
____ ALLERGIES/HAY FEVER
____ HOARSE VOICE, PERSISTENT
____ MOUTH OR TONGUE SORES

LUNGS
____ ASTHMA
____ HAVE COUGHED UP BLOOD
____ INCREASING SHORTNESS OF BREATH WITH ACTIVITY
____ EMPHYSEMA
____ HISTORY OF TUBERCULOSIS
____ CHRONIC COUGH

HEART
____ FREQUENT IRREGULAR HEART BEAT
____ CHEST PAIN OR TIGHTINESS IN CHEST
____ HEART MURMUR _____ Mitral valve prob.
____ HISTORY OF ENLARGED HEART
____ SHORTNESS OF BREATH AT NIGHT
____ SWELLING OF FEET, ANKLES PRESENT AFTER SLEEP
____ HISTORY RHEUMATIC FEVER
____ HIGH BLOOD PRESSURE
____ PREVIOUS HEART ATTACK

ABDOMEN
____ FREQUENT HEARTBURN
____ DIFFICULTY OR PAIN IN SWALLOWING
____ HAVE VOMITED BLOOD
____ RECTAL PAIN OR BLEEDING (BLACK OR BLOODY)
____ RECENT CHANGE IN BOWEL HABITS
____ DIVERTICULITIS or DIVERTICULOSIS
____ COLON POLYPS
____ Last Colon exam date:
____ HEPATITIS / YELLOW JAUNDICE/
____ LIVER DISEASE
____ NAUSEA
____ CONSTIPATION
____ DIARRHEA; how many per day _____
____ ABDOMINAL PAIN WITH Fatty Food
____ SUSPECT ULCERS
____ HEMORRHOIDS
____ HISTORY OF ULCERS
____ BLEEDING

NEURO
____ LOSS OF APPETITE
____ SEIZURE
____ LOSS OF CONSCIOUSNESS
____ DOUBLE VISION
____ MEMORY LOSS
____ NUMBNESS OF HANDS OR FEET
____ NERVOUSNESS AFFECTING HOME LIFE OR WORK
____ SPEECH PROBLEMS
____ STROKE

KIDNEY
____ RECURRENT URINARY TRACT INFECTION
____ URINATION AT NIGHT MORE THAN ONCE
____ BROWN, BLACK OR BLOODY URINE
____ BURNING ON URINATION
____ KIDNEY STONES
____ DIFFICULTY STARTING STREAM
____ PROBLEMS WITH SEXUAL FUNCTION
____ URINARY INCONTINENCE

JOINTS
____ BACK TROUBLE
____ SWOLLEN JOINTS
____ FREQUENT PAINFUL FEET
____ FREQUENT SHOULDER PAIN
____ FREQUENT OR PERSISTENT ACHING OF MUSCLES OR JOINTS
____ GOUT
____ ARTHRITIS
____ OSTEOPOROSIS-How diagnosed?

GENERAL
____ DIABETES: Date diagnosed: _____
____ WEIGHT LOSS GREATER THAN 10 LBS IN LAST YR
____ LOSS OF INTEREST IN EATING
____ SLEEPING DIFFICULTY
____ HERPES IN PAST-genital or face
____ THYROID PROBLEMS
____ BLOOD PRESSURE PROBLEMS
____ MOLE OR SORE NOT HEALING
____ HOT OR COLD NATURED
____ SUSPECT SERIOUS DISEASE OR CANCER
____ LEG CRAMPS WHILE WALKING
____ MORE THIRSTY LATELY
____ FATIGUE
____ FREQUENT CRYING SPELLS, DEPRESSION
____ WORK OR FAMILY PROBLEMS
____ ANXIETY
____ ANEMIA
____ HIGH CHOLESTEROL & last result _____
____

MALES ONLY
____ WEAK URINE STREAM
____ PAINFUL OR SORE GENITALS (PRIVATES)
____ PROSTATE TROUBLE
____ HARD TO EMPTY BLADDER COMPLETELY
____ PERFORM SELF TESTICLE EXAM MONTHLY
____ LAST PSA TEST (if over age 50). DATE _____
____ LAST MENSTRUAL PERIOD _____

FEMALES ONLY
____ VAGINAL DISCHARGE OR PROBLEMS
____ PAINFUL OR SORE GENITALS (PRIVATES)
____ LUMPS OR PAIN IN BREASTS
____ IF YOU SEE A GYNECOLOGIST, LIST NAME
____ Last Bone Density Test _____
____ LAST MAMMOGRAPHY. Date _____
____ LAST PAP SMEAR. Date _____
____ PERFORM SELF BREAST EXAM MONTHLY

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CONSENT FOR MEDICAL TREATMENT

I, _____, hereby consent to the rendering of such care, which may include routine Diagnostic procedures and such medical treatments as the physician(s) consider being necessary under these circumstances. I authorize the physician(s) and other health care professionals to order and/or administer any treatment, local anesthetics, and/or perform such procedures as may be deemed necessary or advisable in the diagnosis and treatment of my injury or illness. This form has been fully explained to me, and I am satisfied that I understand its content and significance.

SIGNED: _____ DATE: _____
Patient Signature

SIGNED: _____ DATE: _____
Signature of Authorized Representative

WITNESS: _____ DATE: _____

HIPAA Authorization form

Alma Lemez, M.D.

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Dr. Lemez to use and/or disclose certain protected health information (PHI) about me to _____.

This authorization permits Dr. Lemez to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

I do not have to sign this authorization in order to receive treatment from Dr. Lemez. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Dr. Alma Lemez

6955 N Mesa St Suite .302C

El Paso, Texas 79912

Signed by: _____ _____

Signature of Patient or Legal Guardian Relationship to Patient

Alma Lemez, M.D.

PATIENT POLICY

Payment is expected at the time services are rendered.

- Please remember that payment is your responsibility regardless of insurance.
- If you have more than one insurance we will need information regarding every single health insurance you are covered under.
- If you are a Medicare beneficiary, Medicare will be billed for you. You will be responsible for deductibles, all non-covered services, etc. according to Medicare guidelines.
- Please note for certain insurance carriers, routine exams & preventative care visits are not covered services.
- All Co-Pays are due at the time of the office visit.
- In the event we are contracted with your insurance company, we will bill for you. If we receive notification that you are not eligible for coverage, you will be responsible for all charges incurred.
- No Shows:
  - There will be a $25 fee charge in the event of failure to call and cancel appointment 24 hours in advance or fail to show for appointment.
  - You will be allowed one no show free of charge.
  - After 3 No Shows without valid reason, you may be fired from our practice.
- There will be a $30 fee for returned checks due to NSF (non-sufficient funds).

Authorization to Release Information for Insurance Purposes: I hereby authorize Dr. Alma Lemez, M.D., PA to release any information acquired in the course of my examination/ treatment. I have read and understand the above statement. I agree to comply with the financial policy of this office and am financially responsible for my account.

SIGNATURE:_____**DATE:**_____

I hereby authorize payment of benefits to be made directly to Dr. Alma Lemez for services provided to me. I understand that I am financially responsible for charges and/or services not covered by this agreement.

SIGNATURE:_____**DATE:**_____