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_____

PARENT or GUARDIAN: Please fill out ONLY if the office visit is for a minor.
CONSENT TO MEDICAL TREATMENT OF A MINOR

Date:_____

Parent's Name(s): _____ DOB:_____

Name of Person Giving Consent:_____

Relationship (Parent, Guardian, Managing Conservator of the child):_____

Address:_____

Phone Number(Home):_____ (Cell):_____

To Whom It May Concern:
I hereby give my permission for ALMA LEMEZ, M.D. to examine and treat my child whose name and age is listed below:

_____who is_____ years of age.
patient's Name

In addition, in the event that I cannot be contacted, I hereby give my consent to the following individuals or institutions to consent to medical treatment for the foregoing child.

_____
Names of Individuals who have care and control over the foregoing child (e.g. babysitter, grandparent)

_____
Names of Institutions (School, daycare, etc.)

Consent to Counseling and Provision of Contraception. Texas permits minors to be treated for sexually transmitted diseases and pregnancy without parental consent and as such, I understand that appointments may include discussion, testing and treatment of sexually transmitted diseases and/or pregnancy issues. Texas does not, however, permit a health care provider to counsel and provide contraception to minors without parental consent except under limited circumstances. Check **Yes** or **No** as to whether you consent to the counseling and prescription of contraception for the minor whose name appears above.

☐ **Yes**, I consent to the counseling and provision of contraception to my child.
☐ **No**, I do not consent to the counseling and provision of contraception to my child.

X_____
Signature of Parent, Guardian, or Managing Conservator

Witnesses to Signature Above:

_____ _____
Name Address

_____ _____
Name Address

PEDIATRIC PATIENT INFORMATION

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

CHILD NAME: _____ **DATE:** ___/___/____
LAST FIRST M.I.

BIRTH DATE: ___/___/____ **AGE:** _____ **GENDER:** M / F

MOTHER'S NAME: _____ **FATHER'S NAME:** _____

PREFERRED PHARMACY: _____
NAME PH. NUMBER

PREVIOUS PHYSICIAN: _____
NAME PH. NUMBER

BIRTH HISTORY

BIRTH WEIGHT: _____ BIRTH LENGTH: _____ MOTHER'S AGE AT BIRTH: _____
DURATION OF PREGNANCY: _____ PLACE OF DELIVERY: _____
MATERNAL ILLNESSES DURING PREGNANCY: _____
SMOKING, ALCOHOL, DRUGS DURING PREGNANCY? Y / N
TYPE OF DELIVERY (please check from list):

- ☐ Vaginal Delivery
- ☐ Vaginal Delivery with Vacuum
- ☐ Vaginal Delivery with Forceps
- ☐ C-section

PROBLEMS WITH LABOR/DELIVERY? _____
DIFFICULTY BREATHING WHEN BORN? Y / N
IS THIS CHILD PART OF A MULTIPLE BIRTH (example: twins)? Y / N
LENGTH OF STAY IN NURSERY _____
BREASTFED/FORMULA/BOTH?_____ IF FORMULA, KIND?_____

MEDICAL CONDITION(S) / HOSPITALIZATIONS (excluding hospitalization for birth): (Example: Asthma, Eczema, Frequent Ear Infections…)

_____
_____
HAD CHICKEN POX? Y / N Date (or approximate if known): ___/___/___
DO YOU FEEL THAT YOUR CHILD HAS A WEIGHT PROBLEM? Y / N

SURGERIES: (Example: Tonsillectomy, Hernia Repair…)_____
_____

ALLERGIES: (Medications, Food, Insects) _____
_____

MEDICATIONS: (Please include vitamins and herbals) _____
_____

MENSTRUAL HISTORY ***(For female teens)***
AGE WITH FIRST PERIOD: _____ LAST MENSTRUAL PERIOD: ___/___/____
REGULAR OR IRREGULAR? _____ DAYS PERIOD LASTS: _____
IS THE FLOW HEAVY, MEDIUM OR LIGHT? _____ PAIN OR CRAMPS? Y / N

PEDIATRIC PATIENT INFORMATION

CHILD'S NAME: _____ **DATE:** __/__/____
LAST FIRST M.I.

DEVELOPMENTAL HISTORY (If over 3 months of age)

AGE CHILD SAT ALONE: _____ AGE CHILD BEGAN CRAWLING:_____
AGE CHILD BEGAN WALKING:_____ AGE CHILD SAID FIRST WORD:_____
AGE CHILD TOILET TRAINED: _____

SOCIAL HISTORY

WHO LIVES IN PRIMARY HOUSEHOLD? _____
_____
NAME(S) AND AGE(S) OF SIBLINGS: _____
_____

ANY PETS IN HOUSEHOLD? Y / N IF YES, WHAT KIND?_____

ANY SMOKERS LIVING IN HOUSEHOLD? Y / N

FIREARM IN HOUSEHOLD? Y / N

ALWAYS WEARS HELMET WHEN BIKING/ROLLERBLADING/SKATEBORADING? Y / N

FOR CHILDREN, ALWAYS USES CAR SEAT OR BOOSTER SEAT? Y / N
FOR TEENS, ALWAYS WEARS SEATBELT? Y / N

SMOKE DETECTORS ON EACH FLOOR OF HOUSEHOLD? Y / N

DAYCARE / SCHOOL ATTENDED: _____GRADE:____

ANY DIFFICULTY WITH SCHOOL? Y / N IF YES, SPECIFY: _____
_____

SPORTS AND ACTIVITIES: _____

ANY SPORTS RELATED INJURIES? Y / N IF YES, SPECIFY:_____

FAMILY HISTORY: (Please list medical conditions that run in your family. For example: asthma, diabetes, sickle cell, bleeding disorder, cancer, mental illness, etc…)

	CONDITION(S)	LIVING?
FATHER:	_____	Y / N
MOTHER:	_____	Y / N
BROTHER(S):	_____	Y / N
SISTER(S):	_____	Y / N
GRANDPARENTS:		
MATERNAL:	_____	Y / N
PATERNAL:	_____	Y / N

PLEASE PROVIDE A COPY OF IMMUNIZATION RECORDS TO THE MEDICAL ASSISTANT.

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

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.

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 policies of this office and am financially responsible for my account.

SIGNATUE: _____ **DATE:** _____

I hereby authorize payment of benefits to be made directly 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:** _____

ALMA LEMEZ, M.D., FAMILY MEDICINE

6955 N Mesa ST Suite 302C EL PASO, TEXAS 79902 PH: (915)500-4307 FAX: (915) 500-4668

Authorization to Treat Minor Patient in Absence of Parent/Guardian

I, _____, the parent and legal guardian of _____,
(name of parent)

_____,

_____,

_____, } List names

hereby authorize _____ _____
(name of person bringing child to the office) (Relationship to child)

_____ _____
(name of person bringing child to the office) (Relationship to child)

to accompany my above-named child to office visits with Alma Lemez, M.D. /

and consent to the examination and/or treatment of my child during the office visits. This authorization includes necessary bloodwork as well as the administration of any recommended immunizations.

This authorization:

- ☐ is effective only on _____.
- ☐ is effective from _____ to _____
- ☐ is effective until revoked by me in writing.

I reserve the right to revoke this authorization at any time by writing to the above named physician.

_____ _____
(Signature of Witness) (Signature of Parent/Guardian)

_____ _____
(Date) (Date)