FORT WORTH PRIMARY CARE
Morvarid Rezaie, DO, FACOI
800 8th Ave, Suite 616
Fort Worth, TX 76104
817-243-7995

Patient Information

Patient Name:_____ DOB:_____
Last First M.I.

Home Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Alt. Phn:_____

SSN:_____ Email:_____

Employer Name:_____ Work Phone:_____

_____ Check here if you have no insurance (Cash Account)

Insurance #1:_____ Insured DOB:_____

Insurance #2:_____ Insured DOB:_____

I, the undersigned, hereby authorize payment directly to Fort Worth Primary Care for medical services rendered. I understand I am financially responsible for all charges not covered or authorized by my insurance company. I also understand that I am responsible for a fee of $ 25.00 for not showing up for the scheduled appointment.

Printed Name:_____

Signature:_____Date:_____

** Please be advised, you will be required to complete this form at your first office visit of each year. The information that you provide is updated yearly and ensures we have accurate information to file a claim on your behalf. Thank you for your assistance with this process.

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Acknowledgement of Privacy Practices

According to the Health Insurance Portability and Accountability Act of 1996 (HIPAA,) patients have certain rights to privacy regarding their protected health information. Your protected health information will be used to:

- Conduct, plan, and direct treatment by the physicians employed by Premier Surgical Associates and will be shared in cooperation with healthcare providers who are involved in your care directly or indirectly.
- To obtain payment from third party payers.
- To conduct normal healthcare operations such as quality assessments and physician certifications.

By signing below, you agree that you have either received or waved your right to receive the Notice of Privacy Practices, containing a complete description of the uses and disclosures of protected health information. You understand that this organization has the right to change its Notice of Privacy Practices at any time. You also understand that you may request from this organization a current copy of the Notice of Privacy practices.

I understand that I may revoke this consent in writing at any time, except to the extent that Premier Surgical Associates has previously released relying on this consent.

Print Patient Name:_____

Do we have permission to:

1. Leave a message at your home regarding appointments and/or treatments?..... ___Yes ___No
2. Leave a message at your place of employment regarding appointments/treatments?.. ___Yes ___No
3. Leave a name and call back number at your home and place of employment?.....___Yes ___No
4. Mail test results and appointment information to your home address on file?..... ___Yes ___No
5. Email at filed email address regarding appointments and treatments?..... ___Yes ___No
6. Discuss your personal information, including appointments and treatments with someone other than yourself? .....
   ___Yes ___No

Name	Relationship	Contact Number

Patient Signature:_____ **Date:**_____

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Physician List

Patient Name:_____DOB:_____

Primary Care Physician:

Address City State Zip Phone

Cardiologist:

Address City State Zip Phone

Pulmonologist:

Address City State Zip Phone

Endocrinologist:

Address City State Zip Phone

Neurologist:

Address City State Zip Phone

Gastroenterologist:

Address City State Zip Phone

Hematologist:

Address City State Zip Phone

Urologist:

Address City State Zip Phone

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Medication List

Patients Name:_____ DOB:_____

Pharmacy:_____ Phone:_____

Allergies:_____

Medication Name (please include any over-the-counter medications)	Dose	Directions

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Patient Medical History Questionnaire

Name:_____ DOB:_____

Please indicate if you have had any of the following symptoms below for at least 2 weeks:

Cardiovascular:

___ Angina/chest pain
___ Shortness of breath with activity

___ Swelling in legs

___ Palpitations
___ Irregular Heartbeat
___ Extremity pain with walking
___ Trouble breathing when lying flat

___ Varicose veins

Gastrointestinal:

___ Acid Reflux
___ Heartburn
___ Abdominal pain
___ Vomiting blood
___ Blood in Stool
___ Nausea
___ Vomiting
___ Constipation

___ Diarrhea

___ Change in appetite

Hematology/Oncology:

___ Easy bleeding
___ Easy bruising
___ Nose bleeding
___ Unintentional weight loss
___ Night sweats
___ Breast lump/pain
___ Post-menopausal bleeding

Pulmonary:

___ Shortness of breath at rest
___ Shortness of breath with activity
___ Wheezing
___ Cough
___ Sputum/phlegm
___ Chest pain with deep breaths

___ Snoring
___ Gasping for air at night
___ Coughing up blood

Genitourinary:

___ Recurrent UTIs
___ Flank pain
___ Blood in urine
___ Burning/pain with urination
___ Trouble starting/stopping stream of urine
___ Waking up more than twice a night to urinate
___ Urgency

___ Frequency

___ Leaking urine

Neurology:

___ Numbness/tingling
___ Headache
___ Low back pain
___ Weakness on one side of body
___ Vision changes
___ Memory loss
___ Tremor

___ Trouble walking

Musculoskeletal:

___ Joint swelling
___ Joint pain
___ Trauma to joint(s)
___ Muscle pain
___ Muscle weakness

Psychiatric:

___ Feeling sad/depressed
___ Lack of interest in hobbies
___ Suicidal thoughts/ideation
___ Feeling anxious/nervous
___ Eating disorders
___ Trouble with sleep
___ Trouble keeping focused/lack of concentration

Endocrine:

___ Heat/cold intolerance
___ Excessive sweating
___ Hair loss
___ Abnormal hair growth
___ Fatigue
___ Weight loss or gain
___ Hot flashes
___ Abnormal menses

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Patient Medical History Questionnaire

Name:_____ DOB:_____

Past Medical History: _____
_____
_____
_____

Surgeries:

	Date/Year	Surgeon Name	Nature of Surgery
1.			
2.			
3.			
4.			
5.			

Hospitalizations:

	Date/Year	Hospital Name	Reason for Hospitalization
1.			
2.			
3.			
4.			
5.			

Preventive Screenings/Procedures:

	Date/Year	Performed By	Result
Colonoscopy			
Mammogram			
Pap smear			
Bone density scan			
Hepatitis C screening (if born 1945-1965)			

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Flu vaccine			
Pneumococcal vaccine			
Tetanus vaccine			

Patient Medical History Questionnaire

Name:_____ DOB: _____

Family History:

	Status: A=Alive D=Deceased	Diabetes	High BP	Heart Disease	Kidney Disease	Stroke	Cancer
Mother	A D						
Father	A D						
Paternal Grandfather	A D						
Paternal Grandmother	A D						
Maternal Grandfather	A D						
Maternal Grandmother	A D						
Brother(s)	A D						
Sister(s)	A D						
Sons(s)	A D						
Daughter(s)	A D						

Social History:

	Currently Use?	If so, how often?	If used in past, when did you quit?
Smoking			
Alcohol			
Illicit Drug Use			

If you smoke currently:

Do you have a desire to quit smoking? _____

Have you tried quitting in the past? If so, how? _____

If you drink currently:

Do you feel a need to cut down on how much you drink? _____

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Has anyone annoyed you by criticizing your alcohol use? _____

Do you feel guilty about how much you drink? _____

Have you ever had an alcoholic drink first thing in the morning to steady your nerves or get rid of a hangover? _____

Wellness Questionnaire

Diet/Nutrition

How many times a day do you eat a meal? _____ Snacks? _____

What is a typical:

Breakfast? _____

Lunch? _____

Dinner? _____

Snack? _____

Do you have a food "weakness"? If so, what is it? _____

Do you drink caffeinated beverages? If so, what, and how much per day? _____

Have you tried any weight loss programs in the past? Yes or No

If so, which? _____

If you wish to lose weight, what is a weight at which you would feel most comfortable and happy with your appearance/health? How do you plan on working towards that weight loss?

_____

Exercise

Do you exercise? Yes or No (circle one)

If yes, what type of exercise do you perform? _____

How many times a week do you exercise? _____

Do you have any pain during or after exercise? ___ If yes, where?_____

Do you become short of breath with exercise? ____ If yes, how quickly? _____

How quickly do you recover/regain your breath after resting? _____

Any other symptoms brought on by exercise/excessive exertion? _____

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Do you have any exercise goals (e.g. participate in 5K, hiking)? _____

Do you have access to equipment (either home or in a gym)? _____

Do you play any sports? ___ If yes, what and how often? _____

Sexual History

Are you sexually active? Yes or No (circle one)

What is your sexual preference (male/female/both)? _____

Are you content with your sexual health/level of activity? Yes or No (circle one)

Why or why not? _____

How many partners do you have currently? _____ Lifetime? _____

Do you use any sort of protection to prevent disease transmission and/or pregnancy? Yes or No

If so, what kind? _____

Mental Health

Overall, how happy are you in life? _____

Over the past 2 weeks, how often have you experienced the following:

	Never	Fewer than ½ the days	More than ½ the days	Every day
Sleeping too much/too little				
Lost interest in things you normally enjoy				
Feel guilty/like you have let family/friends down				
Low energy				
Loss of concentration/focus				
Low or high appetite				
Feeling either restless/fidgety or like you are in “slow-mo”				
Thoughts of hurting yourself or that you’re better off dead				

Do you feel anxious/nervous/worried? Yes or No

If so, can you pinpoint what is causing you to feel this way? _____

Is the cause something that you expect to be resolved in the next 30 days? Yes or No

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How do you cope with your stress? _____

Do you feel like you have a good support system of people in your life? Yes or No

If so, who is included in that group? _____

Controlled Substance Contract

Patient Name: _____ Acct #: _____

Address: _____ DOB: _____

If you receive any controlled substance prescription from Dr. Morvarid Rezaie, you must agree to the following statements: (please initial and sign)

____ I will not accept any narcotic prescriptions from another doctor.

____ I will be responsible for making sure that I do not run out of my medications on weekends and holidays because abrupt discontinuation of these medications may cause severe withdrawal symptoms. I will give a 72-hour prior notice for refills.

____ I understand that I must keep my medications in a safe place.

____ I understand that Dr. Rezaie will not supply additional refills for the prescriptions of medications that I may lose.

____ If my medications are stolen, Dr. Rezaie will refill the prescription one time only if a copy of the police report of the theft is submitted to the physician's office.

____ I will not give or share my prescriptions with anyone else.

____ I will only use one pharmacy.

Pharmacy name/number:

_____

____ I will keep my scheduled appointments with Dr. Rezaie unless I give notice of cancellation 24 hours in advance.

____ I agree to refrain from all mind/mood-altering/illicit/addicting drugs unless authorized by Dr. Rezaie. This includes tranquilizers, sleeping pills, anxiety medications, and alcohol.

____ I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.

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____ I understand that if I break this agreement my physician reserves the right to stop prescribing pain controlled substance medications for me.

Patient's Printed Name: _____ Acct # _____

Patient's Signature :_____ Date: _____