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. Phone: _____

SSN:_____ Email:_____

Responsible party/Guarantor

Name: _____DOB: _____

Relationship to patient: _____ Phone: _____

Employer Name: _____ Work Phone: _____

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

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 Fort Worth Primary Care 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 Fort Worth Primary Care has previously released relying on this consent.

Print Patient Name: _____ **Date of Birth**: _____

Do we have permission to:

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

Name	Relationship	Contact Number

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Patient Signature:_____ **Date:**_____

Physician List

Patient Name: _____DOB:_____

Primary Care Physician:

_____

Address City State Zip Phone

Cardiologist (Specializes in the Heart)**:**

_____

Address City State Zip Phone

Pulmonologist (Specializes in the Lungs)**:**

_____

Address City State Zip Phone

Endocrinologist (Specializes in the Endocrine Glands and Hormones)**:**

_____

Address City State Zip Phone

Neurologist (Specializes in Nerves and Nervous System)**:**

_____

Address City State Zip Phone

Gastroenterologist (Specializes in the Stomach and Intestines)**:**

_____

Address City State Zip Phone

Hematologist (Specializes in Blood Diseases)**:**

_____

Address City State Zip Phone

Other Specialists:

_____

Address City State Zip Phone

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Patients Name: _____ DOB: _____

Local Pharmacy Name: _____

Pharmacy Phone: _____ Pharmacy Address: _____

Mail-Order Pharmacy Name: _____ Phone: _____

Allergy to Medications

Medication Name: _____ Reaction: _____ Year: _____

Medication Name: _____ Reaction: _____ Year: _____

Medication Name: _____ Reaction: _____ Year: _____

Medication Name: _____ Reaction: _____ Year: _____

Medication List

Medication Name (including any over-the-counter medications)	Dose (Mg, Mcg, Units)	Directions (As written on the bottle)

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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 (please circle all applicable):

High Blood Pressure Diabetes (insulin? Y/N) High Cholesterol Heart Disease

Heart Attack Stroke Chronic Kidney Disease (Dialysis Y/N?) Cancer (Location?_____)

COPD/Emphysema Asthma Thyroid Disease Liver Disease/Cirrhosis GERD

Stomach Ulcers Diverticulosis/-it is Osteoporosis Osteoarthritis

Other: _____

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)			
Flu vaccine			
Pneumococcal vaccine			
Tetanus vaccine			

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Patient Medical History Questionnaire

Name:_____ DOB: _____

Family History:

	Status: A=Alive D=Deceased	Diabetes	High BP	Heart Disease	Mental Illness	Cancer (List Type)	Other Disorders
Father	A D						
Mother	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	Yes	No	Cigarettes per day? _____	
Alcohol	Yes	No		
Illicit Drug Use	Yes	No		

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? _____

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? _____