Optimum Health/David Miloy MD PA
1411 Water St Kerrville, Tx 78028
895 5599

History Form

Patient Name: _____ Date: _____ Please check all that you have a personal history of:

( ) Asthma
( ) COPD
( ) Pneumonia
( ) High blood pressure
( ) High cholesterol
( ) Heart attack
( ) Heart murmur
( ) Artificial heart valve
( ) Atrial Fibrillation
( ) Eye disease
( ) Hearing disorder
( ) Cancer: type_____
( ) Seizures
( ) Migraines
( ) Stroke
( ) Neck/back pain
( ) Osteoporosis

( ) Kidney disease
( ) Hepatitis
( ) Incontinence
( ) GERD (reflux)
( ) Diabetes
( ) HIV
( ) Anemia
( ) Bleeding disorder
( ) Blood clot
( ) Thyroid disorder
( ) Depression
( ) Anxiety
( ) Mental illness: Type_____
( ) Fibromyalgia
( ) Other: _____
_____
_____

Please list all surgeries and date of surgeries if known:
_____
_____
_____

Please list all hospitalizations:
_____
_____
_____

Please list all doctors that you currently see:
_____
_____
_____

Social History: Marital Status: (circle one) Single Married Widowed Divorced
Do you use alcohol? YES or NO If yes, how many drinks per week? ___ per day? ___
Do you use tobacco or e- cigarette? YES or NO. If yes, what type_____
If YES, How much per day? _____ Age started? ____ Age Quit? _____
Recreational drug use? Type? _____

Employment status (circle) WORKING RETIRED DISABLED: reason_____
Occupation: _____
Do you always wear a seatbelt? YES or NO ____
Do you have children? YES or NO___ If yes, what are their birth years?_____

Family History:

Father: Living: Yes or no? ____ Approximate age of death if deceased_____ Medical problems and age of onset if known:_____
_____
____

Mother: Living: Yes or no? ____ Approximate age of death if deceased_____ Medical problems and age of onset if known:_____
_____
____

Brothers: Living: Yes or no? ____ Approximate age of death if deceased_____ Medical problems and age of onset if known:_____
_____
____

Sisters: Living: Yes or no? ____ Approximate age of death if deceased_____ Medical problems and age of onset if known:_____
_____
____

Family history of alcohol abuse? Yes or no____
Family history of depression? Yes or no____

Immunizations/Screening Tests:

Tetanus vaccination_____ Pneumonia vaccination_____ Shingles vaccination_____ Gardasil/HPV vaccination_____ Hepatitis B vaccination_____ Flu vaccination_____ Tdap vaccination_____ PPD(TB test)_____ Colonoscopy_____ PSA_____ Eye exam_____ Stress test_____ Bone density test_____ Sleep study_____ Mammogram_____

Review of Systems:
(Please circle any of the following that you are experiencing)

weight loss/gain
fevers
headaches
rash
itching
leg swelling
hives
congestion
ear pain
sore throat
chest pain

Review of Systems Continue:

palpitations
cough
wheezing
shortness of breath
nausea diarrhea
abdominal pain
urinary frequency
incontinence
burning with urination
vaginal discharge
irregular periods
erectile dysfunction
joint pain
muscle spasm neck/back pain
heat/cold intolerance
seizures
numbness
dizziness
depression
anxiety
trouble sleeping

Other: _____

Medication Allergies:

_____
_

Other Allergies:

_____
_

Medications:

	Name	*Dose*	*Frequency*		*Name*	*Dose*	*Frequency*
1.				8.			
2.				9.			
3.				10.			
4.				11.			
5.				12.			
6.				13.			
7.				14.			

Advanced Directives:

Do you have a Living Will? Yes or no_____ Do you have a Power of Attorney for health care?

Yes or no_____ If yes, Name/Phone #_____

Optimum Health/David Miloy MD, PA

1411 Water St., Kerrville, Tx 78028
Phone: 830 895-5599
Fax 830 895-8686

Medical Records Request

Authorization For Release of Confidential Medical Information

PATIENT NAME: _____ BIRTHDATE: _____
ADDRESS: _____ TELEPHONE: _____

I hereby authorize the release of medical records and/or information regarding my medical situation, and if applicable, all specific lab test (including HIV infections) related to my medical condition.

_____ Complete Medical Records
_____ Hospital Records
_____ Laboratory Test Results
_____ Other (Specify)

_____ X-Ray Reports only
_____ Consultation Reports
_____ Progress Notes

I hereby authorize this office:

____ to RECEIVE the above information from:
____ to TRANSMIT the above information to:

_____

_____

_____

_____

I understand I may withdraw this authorization at any time but must do so in writing. Above information may only be shared with another person per my written release of approval.

_____

Patient Signature Date

_____

Witness Date

OPTIMUM HEALTH
DAVID R. MILOY, MD PA
Attn: HIPAA Officer
1411 WATER ST.
KERRVILLE, TEXAS 78028
830-895-5599

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

_____

_____

Patient Name: _____
(Please Print Name)

Patient Date of Birth: _____

SIGNATURES:

Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____

Witness (optional) : _____Date:_____

NOTICE: This sample **Notice of Privacy Practices** was prepared by the Texas- based law firm of Jackson Walker, L.L.P. Any questions regarding this material are subject to the following paragraphs and should be directed to your own legal counsel or to Jeffery Drummond at (214) 953-5781. The Texas Medical Association (TMA) has no responsibility for the content of this material and makes no representation regarding the accuracy, currency, or completeness of this information.

Jackson Walker, L.L.P. and TMA provide this information as a commentary on legal issues with the understanding that it is not intended to provide advice on any specific legal matter. Due to the specific circumstances of a particular medical practice, some providers may be subject to other requirements not covered by the provisions of this document (for example, certain covered entities dealing with substance abuse treatment services will also be subject to the requirements of 42 CFR Part 2 disclosure restrictions), and should consult their own attorney. This information should NOT be considered legal advice and receipt of it does not create an attorney- client relationship. **This is not a substitute for the advice of an attorney.** Jackson Walker, L.L.P. and TMA provide this information with the express understanding that 1) it does not create an attorney-client relationship with you, 2) neither TMA, Jackson Walker, L.L.P. nor its attorneys are engaged in providing legal advice to you, and 3) that the information is of a general character.

Although Jackson Walker, L.L.P. and TMA have attempted to present materials that are accurate and useful, some materials may be outdated, and Jackson Walker, L.L.P. and TMA shall not be liable to anyone for any inaccuracy, error or omission, regardless of cause, or for any damages resulting therefrom. Any legal forms are only provided for the use of physicians in consultation with their attorneys. You should not rely on this information when dealing with personal legal matters; rather, legal advice from retained legal counsel should be sought.

Optimum Health/David Miloy MD PA

PATIENT REGISTRATION FORM

Social Security #:_____-____-_____ Date of Birth: _____/_____/_____ Sex: Male/ Female

Last Name: _____ Middle Initial: _____First Name: _____

Street Address: _____

City/State/Zip: _____

Home Phone #:_____Cell #:_____

Email Address:_____ (
You will receive an invitation to register for our secure online portal via email)

Patient's Employer: _____Work #:_____

Employer's Address: _____ Occupation: _____

City: _____State/Zip: _____

Marital Status (circle one): Single, Married, Widowed, Separated, Divorced, Other

Spouse's Name: _____

If you have Medicare, are you or your spouse currently working? (circle one) Yes No Primary Insurance Information:

Name of Insurance: _____

Name of Subscriber: _____SS#:_____-_____-_____

DOB of Subscriber: _____/_____/_____Subscriber's Employer:_____

Subscriber's Employer's Address: _____

Secondary Insurance Information:

Name of Insurance: _____

Name of Subscriber: _____SS#:_____-_____-_____

DOB of Subscriber: _____/_____/_____Subscriber's Employer: _____

Subscriber's Employer's Address: _____

First Emergency Contact:
Name:
_____Phone#:_____Relationship:_____
_

Second Emergency Contact:
Name:
_____Phone#:_____Relationship:_____
_

Ethnicity (circle one): Hispanic, Non-Hispanic, Patient Declines

Race (circle one): American Indian, Asian, Black or African American,

Native Hawaiian or other Pacific Islander, White, Patient Declines

Preferred Language (circle one): English, Spanish, Other_____

Preferred method of communication for follow up care (circle one): Phone, Mail, Patient Portal

How will you be paying today? (circle one) Cash, Check, Visa, MasterCard,

It is the policy of Optimum Health/ David Miloy MD PA. to communicate only with the patient using the contact information provided by the patient. HIPAA of 1996 establishes the right for patients to request alternative methods of communication from our office. If there is anyone, other than yourself, that you would like us to release information to, please list them below. Please note that we will not be able to communicate with anyone other than you without your written permission.

Name:
_____Relationship:_____

Name:
_____Relationship:_____

(Circle one or both) Medical Info / Billing Info.

If this request changes you are responsible for notifying Optimum Health/David Miloy MD PA.

I AUTHORIZE THE PHYSICIAN IN CHARGE TO ADMINISTER MEDICAL CARE AS IS NECESSARY. I have read the patient- physician agreement and understand fully services offered and monthly fees due.

I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR CHARGES INCURRED AT Optimum Health/David Miloy MD PA REGARDLESS OF THIRD PARTY LIABILITY. I AGREE THAT OPTIMUM HEALTH/ DAVID MILOY MD PA MAY RELEASE ANY MEDICAL INFORMATION NECESSARY FOR FILING MY CLAIM.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION IN POSSESSION OF OPTIMUM HEALTH/ DAVID MILOY MD PA TO ANY CONSULTING MEDICAL PERSONNEL FOR THE PURPOSE OF RENDERING TREATMENT OR TO CONTINUE MY CARE.

Patient's Signature: _____Date:_____

Signature of Personal Representative: _____Date:_____