PATIENT INFORMATION

PATIENT'S NAME:_____ Age_____ Birthdate_____
Last First Middle

Please circle one: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow Sex _____

Address:_____
Street City, State, Zip Code

Home Phone:_____ Business Phone:_____

Employer:_____ Address:_____

Occupation:_____ City, State, Zip:_____

Social Security No.:_____ Driver License No.:_____

Name of nearest relative (not living with you):_____ Phone:_____

IF PATIENT IS UNDER 18 YEARS OF AGE OR RESIDING WITH PARENT, PLEASE COMPLETE:

Father's Name:_____ Mother's Name:_____

Father's Employer:_____ Mother's Employer:_____

Employer's Address:_____ Employer's Address:_____

Business Phone:_____ Business Phone:_____

Name of Responsible Party:_____

Was this an accident: ☐ Yes ☐ No on the job: Yes ☐ No ☐ Date of accident:_____

Have you had any surgery within the last 90 days? Yes ☐ No ☐ Yes? Date:_____

How do you plan to pay for today's visit? Cash____ Check____ Visa____ MC____ AMEX____ Discover___

Primary Insurance

Insurance Company:_____

Insurance Policy No.:_____

Insurance Group No.:_____

Insured Name:_____

Relationship to Insured:_____

Insured Employer:_____

Insured Social Security No.:_____

Insured Date of Birth:_____

Insured Address (if different from patient)

_____

_____

Is patient covered by additional insurance? Yes No

Insurance Company:_____

Insurance Policy No.:_____

Insurance Group No.:_____

Insured Name:_____

Relationship to Insured:_____

Insured Employer:_____

Insured Social Security No.:_____

Insured Date of Birth:_____

Insured Address (if different from patient)

_____

_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to **Cheryl P. Lopez, D.O., P.A.** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submission.

Responsible Party Signature_____ Relationship_____ Date_____

CHERYL P. LOPEZ, D.O.

3880 Parkwood Blvd., Suite 303
Frisco, Texas 75034
(214) 618-7952

Health History

Patient Name:_____ Sex: Today's Date:_____

Age:_____ Date of Birth:_____ Date of last physical examination:_____

What is your reason for visit?_____

Symptoms

Check (√) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache/Migraine
- ☐ Loss of sleep
- ☐ Loss of consciousness
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Weight gain
- ☐ Weight loss

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders
- ☐ Joint swelling
- ☐ Joint stiffness

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Dry heaves
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Food intolerance
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting with blood

CARDIOVASCULAR
- ☐ Chest pain/angina
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heartbeat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE,EAR,NOSE,THROAT
- ☐ Bleeding gums
- ☐ Blindness
- ☐ Blurred vision
- ☐ Crossed eye
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Ear ache
- ☐ Ear discharge
- ☐ Eye itching
- ☐ Eye pain
- ☐ Eye redness
- ☐ Eye trauma
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Runny nose/Sinus problem
- ☐ Sore throat
- ☐ Wear contacts
- ☐ Wear glasses
- ☐ Vision - Flashes
- ☐ Vision- Halos

PSYCHIATRY
- ☐ Anxiety
- ☐ Changes in sleep/eating/sex habits
- ☐ Stress
- ☐ Suicide attempt
- ☐ Suicide ideation

SKIN
- ☐ Bruise easily
- ☐ Change in moles
- ☐ Dryness
- ☐ Itching
- ☐ Jaundice
- ☐ Lumps
- ☐ Rash
- ☐ Scars

RESPIRATORY
- ☐ Bloody sputum
- ☐ Cough
- ☐ Difficulty breathing
- ☐ Shortness of breath
- ☐ Sputum
- ☐ Sweating (night)
- ☐ Wheezing

NEUROLOGIC
- ☐ Difficulty speaking
- ☐ Incoordination
- ☐ Loss of balance
- ☐ Loss of sensation
- ☐ Paralysis
- ☐ Seizures
- ☐ Tremors

MEN ONLY
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penile discharge
- ☐ Sore on penis
- ☐ Other_____

WOMEN ONLY
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple changes
- ☐ Nipple discharge
- ☐ Vaginal discharge
- ☐ Other_____

Date of last menstrual period:
_____

Date of last Pap Smear:
_____

Result: Normal Abnormal

Have you had a mammogram? Y/N

If Yes, Date:_____

Result: Normal Abnormal

Are you pregnant? Yes / No

Number of Children_____

How many pregnancies?_____

Number of miscarriages?_____

Conditions

Check (√) conditions you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Claudication
- ☐ Congestive Heart Failure
- ☐ Coronary Heart Bypass Graft
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Gallstones
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lupus
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Murmur (Heart)
- ☐ Myocardial Infarction
- ☐ Orthostatic Hypotension
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pancreatitis
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Psoriasis
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Sarcoidosis
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Syphilis
- ☐ Thyroid Problems
- ☐ Thrombophlebitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Medications

List Medications you are currently taking

_____

_____

_____

Allergies

List allergies to medications, food, etc

_____

_____

_____

Pharmacy Name:_____ Pharmacy Phone No:_____

Pharmacy Address:_____

(Continue at the back)

Family History

Fill in health information about your family

Relation	Age	State of Health	Age of Death	Cause of Death	Check (√) if, your blood relatives had any of the following		
						Disease	Relationship to you
Father						Arthritis, Gout	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Stroke	
Sisters						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? Yes No

If yes, Please give approximate dates, _____

Serious Illness / Injuries	Date	Outcome

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature Date

Pregnancies

Year of Birth	Sex of Birth	Complications, if any

Health Habits

Check (√) which substances you use and describe how much you use.

	Caffeine	
	Drugs	
	Tobacco	
	Alcohol	
	Other	

Occupational

Check (√) if your work exposes you to the following:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation:

Reviewed by: (Must be Clinic's employee)

Date

Cheryl P Lopez DO PA
3880 Parkwood Blvd., Suite 303
Frisco, Texas 75034
(214) 618-7952
Fax: (214) 618-7081

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to **CHERYL P LOPEZ DO PA** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefits payments. I hereby authorize the doctor and clinic to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic, to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursements and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with **CHERYL P LOPEZ DO PA** in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

Should this assignment be prohibited in part or whole under an anti-assignment provision of my policy/plan, please advise and disclose to **CHERYL P LOPEZ DO PA** in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonable expected to be effective and such anti-assignment waived.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____
Print Name of Insured / Guardian Date

_____
Signature of Insured / Guardian

Cheryl P. Lopez, D.O., P.A.

3880 Parkwood Blvd., Suite 303
Frisco, Texas 75034

Tel: (214) 618-7952
Fax: (214) 618-7081

Patient Financial Responsibility Policy

In order to reduce confusion and misunderstanding between our patients and the PRACTICE, we have adopted the following policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- Unless other arrangement have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept VISA, MasterCard, Discover, American Express, Cash and Checks.
- Returned Check Fee is $ 35.00 dollars.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept assignment of benefits. This means that we will bill those plans for which we have agreement and will only require you to pay the authorized co-payment and / or deductible at the time of service. It is the policy of our office to collect this co-payment and / or deductible when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.
- In the event that your health plan determines a service to be “not covered”, you will be responsible for the complete charge. Should you not respond within a 90-day period for any unpaid balances, the amount will be turned over to a collection agency including all additional fees, legal or otherwise, as allowed by the State of Texas.
- Unfortunately, the office are not always aware of the particular details of each insurance plan. Therefore, please be sure you are aware of any exclusions and/or provisions of your plan. Your insurance is a contract between you, your employer, and the insurance company.

Missed Appointment

- It is the policy of our office that should you fail to show up for an appointment and do not notify the office at least three hours prior to the appointment, you will be billed a “missed appointment” fee of $75.

Minor Patients

- Minors cannot be seen at our office without the legal guardian’s consent. Grandparents, Stepparents, and childcare practitioners must have written consent to treat from the legal guardian. For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the PRACTICE and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the PRACTICE.

_____
Printed Name of the Patient

_____ _____
Signature of Patient or Responsible Party if a Minor Date

Cheryl P. Lopez, D.O., P.A.

3880 Parkwood Blvd., Suite 303
Frisco, Texas 75034

Tel: (214) 618-7952
Fax: (214) 618-7081

Controlled Substance Policy

It is the policy of this office that we do not routinely prescribe controlled substances such as narcotics (Vicodin, Percocet, Norco etc.) or benzodiazepines (valium, xanax, ativan, etc.). There are occasions where controlled substances are warranted however, they will only be prescribed in a very limited quantity and will not be refilled. These substances will also not be prescribed over the phone. If you have a condition that you feel requires either large quantities of such medications or long term use of such medications, we will be happy to refer you to the appropriate specialist for your condition. We cannot provide refunds for patients who are seen but feel they require larger dosages, quantities, or refills of controlled substances. _____ Initials

Prescription Medication Policy

For your safety, it is the policy of this office that we do not routinely call-in antibiotics or other prescriptions to treat acute illnesses over the phone. We ask you to come to the office so we can properly evaluate you and treat you in a safe and effective manner.

It is also the policy of this office to deny fax or phone prescription refill request. Patients requesting prescription refill must make an appointment with the office.

By signing below, I acknowledge that I have read and understood the controlled substance and prescription medication policy of Cheryl P Lopez, DO PA.

_____
Printed Name of the Patient

_____ _____
Signature of Patient or Responsible Party if a Minor Date

Cheryl P. Lopez, D.O., P.A.

PATIENT CONSENT FORM

Use and disclosure of health information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, **CHERYL P. LOPEZ, D.O., P.A.** originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

The **CHERYL. P. LOPEZ, D.O., P.A.**'s *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this consent. I understand that **CHERYL P. LOPEZ, D.O., P.A.** reserves the right to change the *Notice of Privacy Practices.* Prior to implementation of the revised *Notice of Privacy Practices*, the revised Notice will be mailed to me if I provide my address below. I understand that I have the right to restrict the use and/ disclosure of my personal health information for treatment, payment or healthcare operations and that **CHERLY P. LOPEZ, D.O., P.A.** is not required to agree to the restriction requested. I may revoke this consent at any time in writing except to the extent **that CHERYL P. LOPEZ, D.O., P.A.** has already taken action in reliance on my prior consent. The consent is valid until revoked by me in writing.

- ☐ I request the following restrictions on the use and/disclosure of my personal health information.

_____

_____

_____

_____

I further understand that any and all records, whether written, oral or electronic format, are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law.

I have been provided and have reviewed the **CHERYL P. LOPEZ, D.O., P.A**.'s *Notice of Privacy Practices* dated December 1, 2002.

_____ _____

Signature of Patient or Legal Representative, Date Witness, Date

_____ _____

Print Name of Patient or Legal Representative Print Name of Witness

*I request that changes to *Notice of Privacy Practices* be sent to me at this address:

_____

_____

_____

CHERYL P. LOPEZ DO PA
3880 PARKWOOD BLVD., SUITE 303
FRISCO, TEXAS 75034
Tel: (214) 618-7952
Fax: (214) 618-7081

CHERYL P. LOPEZ, DO
Board Certified Family Medicine

Patient Name:_____

GENERAL CONSENT FOR TREATMENT

I, knowing that I am suffering from a condition requiring diagnostic and medical treatment do hereby voluntarily consent to such procedures and care and to such medical, or other services under the general and specific instructions of:

CHERYL P. LOPEZ, D.O.

and/or her assistants or her designee as is necessary in her judgment.

I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatments and examination by:

CHERYL P. LOPEZ, D.O.

I also acknowledge that copies of my chart may need to be faxed to a hospital or another physician in continuation of treatment and care by:

CHERYL P. LOPEZ, D.O.

_____ _____

Patient/Guardian Signature Date