SAN ANTONIO INFECTIOUS DISEASES CONSULTANTS

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PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Full Name _____ D.O.B. _____/_____/_____ Marital Status _____
Please Print

SS#_____-_____-_____ Sex: M _____F _____ Home Phone#: ( ) _____ Cell#: ( )_____

Address _____ City _____ State _____Zip_____

Work Phone: ( )_____ Please Circle Phone # to contact with lab results & Appt. Info: Home Cell Work

Patient Employer _____Employer Address_____ City_____ State __ Zip_____

Race: □ American Indian or Alaskan Native □ Asian □ Native Hawaiian or Other Pacific Islander □ Black or African American
□ White □ Hispanic □ Other Race □ Unreported/Refused to Report

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Refused to Report

Preferred Language: □ English □ Spanish □ Russian □ Indian (Includes Hindi & Tamil) □ Other

Emergency Contact _____Phone:( ) _____Relationship_____

Primary Care Physician: _____ Referring Physician: _____

Is this injury work related? **Yes / No** If yes, Date of injury: _____ Claim#: _____

□ Yes, I would like to have access to my medical information online. My personal(non-work) email address: _____
□ No, I **do not** want to access my medical information online. Reason: □ Do not have E-mail □ Do not want to be web-enabled
□ Do not want to share E-mail address □ Other

Primary Insurance

Insurance Co._ _____ ID# _____ Group# _____

Policy Holder _____ M_____F _____ Date of Birth: _____/_____/_____

Relationship_____ SS# _____Employer: _____

Additional Insurance

Insurance Co. _____ ID# _____ Group# _____

Policy Holder _____ M_____F _____ Date of Birth: _____/_____/_____

Relationship_____ SS# _____Employer: _____

Request for Confidential Communication

I give my permission to allow the following individuals to discuss my Personal Health Information with the Physicians and Staff of SAIDC:

Name: _____Relationship: _____ Phone:_____

Name: _____Relationship: _____ Phone:_____

Pharmacy Information

Primary Pharmacy: _____Phone# _____Address_____City/State/Zip_____

Secondary Pharmacy: _____Phone# _____Address_____City/State/Zip_____

I authorize SAIDC to verify my prescription benefit and perform an external medication history check through e-prescribing which helps ensure the medication is covered under my benefit plan.

_____ _____
Patient / Responsible Party signature Date

Assignment and Release

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I also certify that the information I have reported with regard to my insurance coverage is correct and that services rendered today will remain my sole obligation despite the status of my insurance company's reimbursement. I do hereby request that payment from my insurance company be made directly to the physician.

_____ _____
Patient / Responsible Party signature Date

San Antonio Infectious Diseases Consultants

This questionnaire consists of 6 pages. Please be sure to fill out all pages. **Thank you for your cooperation.**

Name _____ Age_____ Sex_____ Date_____

Marital Status S M W D Religion _____ Education_____

Current Physician _____ City_____

Who referred you to the doctor? _____

Why are you coming to see the doctor? _____

_____

What **other medical problems** do you have? _____

_____

_____

OPERATIONS: List Your Operations. Do not omit minor operations (tonsils, vasectomy, D&C, etc.).

Operation	Date	Hospital	Surgeon

HOSPITALIZATIONS: List your hospitalizations other than those described above.

Date	Illness	Hospital	Physician

INJURIES: List your serious injuries and broken bones with approximate dates.

_____

_____

_____

Name: _____ Date of Birth: _____

MEDICATIONS: List all medications including birth control pills, sleeping pills, vitamins, etc.

Medication	Dosage	How long taken?

Have you ever taken blood pressure pills? _____
How many pain pills or headache pills do you take in an average week? _____

DRUG ALLERGIES: List all medication allergies (such as penicillin, sulfa, aspirin, etc.).

Medication	Type of Reaction	Date of Reaction

ALLERGIES: List any allergies you have other than those caused by medications. _____

_____

HABITS: List your **average daily consumption** of the following:

Whiskey _____ Coffee _____
Beer _____ Tea _____
Wine _____ Caffeinated sodas _____
Marijuana _____ Cigarettes_____
LSD, heroin, cocaine, amphetamines _____ Pipes & cigars _____

Do you engage in a regular program of exercise? _____
What type of work do you do? _____
What type of work have you done in the past? _____
What type of work does your spouse do? _____

INFECTIONS: Please give the approximate age at which you had each of the following infections, if ever:

Tuberculosis _____	Typhoid _____	Mononucleosis _____	Syphilis _____
Hepatitis _____	Rheumatic fever ____	Diphtheria_____	Gonorrhea _____
Malaria _____	Polio _____	Herpes _____	Meningitis _____

IMMUNIZATIONS: Indicate the last year that you received each of the following immunizations, if ever.

Tetanus _____	Polio _____	Pneumonia _____
Measles (MMR) _____	Hepatitis A _____	Yellow fever _____
Typhoid _____	Hepatitis B _____	Influenza _____

Name: _____ Date of Birth: _____

Have you ever had a skin test for TB? _____ Results: _____ Date: _____

TRAVELS: List the countries you visited in the past 5 years. _____

_____

Have you ever lived in the following areas?
Arizona _____ Ohio Valley_____ California _____
Birthplace? _____
How long have you lived in San Antonio? _____

PETS: List any pets you have in your home. _____
Have you had a pet die recently? _____
Have you ever had any allergic reactions to pets? _____

FAMILY HISTORY

Relationship	Age	Living?	Deceased?	Medical Problems
Spouse				
Mother				
Father				
Brother (s)				
Sister (s)				
Children				

Who in your family not listed above has the following diseases?

Diabetes	Heart disease	Stroke
Cancer	Kidney disease	Kidney stones
Gout	Goiter	Ulcers
Nervous breakdown	Arthritis	Seizures
Bleeding disorder	Glaucoma	Tuberculosis
Hypertension (high blood pressure)		

Please check the appropriate response

	Yes	No	Remarks
Recent weight loss/gain			How many pounds?
Poor appetite			
Weakness			
Fever			
Night sweats			
Frequent headaches			
Dizziness or light headedness			
Itching			
Rash			
Hives			
Acne			
Psoriasis			
Eye pain			
Double vision			

Name: _____ Date of Birth: _____

Blurred Vision	Yes	No	Remarks
Earache			
Motion sickness			
Ringing/noises in ears			
Difficulty hearing			
Frequent nasal stuffiness			
Frequent nosebleeds			
Postnasal drip			
Hoarseness			
Frequent sore throats			
Trouble smelling			
Dentures			
Dry mouth			
Sore/burning tongue			
Dental problems			
Changes in taste			
Trouble swallowing			
Goiter			
Frequent swollen glands			
Breast tenderness			
Nipple discharge			
Breast lumps			
Cough			
Coughing up blood			
Pneumonia			
Phlegm production in AM			
Coughing after eating			
Wheezing			
Emphysema			
Bronchitis			
Frequent chest colds			
Heart palpitations			
Irregular heartbeat			
Fainting spells			
Swelling in the ankles			
Leg cramps			
Shortness of breath			
Night cough			
Chest pain/discomfort			
Heart attack			
Heart murmur			
High blood pressure			
Rheumatic fever			

How many pillows do you sleep on? _____
Do you awaken at night short of breath? _____
Can you climb 2 flights of stairs without stopping? _____
Have you lost any hair over your lower legs or toes? _____

Name: _____ Date of Birth: _____

	Yes	No	Remarks
Vomiting			
Diarrhea			
Constipation			
Change in bowel habits			
Jaundice or hepatitis			
Clay colored stools			
Tea colored urine			
Vomiting blood or coffee ground material			
Black or tarry stools			
Milk intolerance (diarrhea/gas)			
Food sensitivities			
Mucous in stools			
Fatty food intolerance			
Belching or bloating			
Gallbladder disease			
Ulcers			
Heartburn			
Liver disease			
Cirrhosis			
Hiatal hernia			
Pancreatitis			
Diverticulitis			
Blood on the toilet paper			
Rectal itching			
Hemorrhoids (piles)			

How often do you move your bowels? _____

How often do you take a laxative or enema? _____

	Yes	No	Remarks
Kidney stones			
Blood in urine			
Urgency			
Burning on urination			

How many times you get up at night to urinate? _____

How long have you been doing this? _____

MALE ONLY	Yes	No	Remarks
Discharge from penis			
Prostatitis			
Pain in testicles			
Are you circumcised?			
Dribbling after urination			
Difficulty starting urination			
Decrease in stream size			

Female Only	Yes	No	Remarks
Discharge from vagina			
Vaginal itching			
Bleeding between periods			

Name: _____ Date of Birth: _____

During pregnancy did you have any of the following?

Diabetes			
Toxemia			
Jaundice			
High blood pressure			
Seizures			
Protein in the urine			

Date of last pelvic examination _____
Date of last Pap smear _____
Date of last menstrual period _____
What form of birth control do you use? _____
Do you dribble urine when coughing or sneezing? _____
How many pregnancies have you had? _____
How many live births? _____
Birthweight of largest baby? _____

All Patients:	Yes	No	Remarks
Arthritis			
Swollen/stiff joints			
Bone pain			
Muscle pain			
Low back pain			
Varicose veins			
Phlebitis			
Fingers turning blue or white in the cold			
Epilepsy/seizures			
Strokes/paralysis			
Muscle weakness			
Tremors			
Numbness			
Neuritis			
Bursitis			
Thyroid disease			
Change in hair/skin texture			
Diabetes			
Anemia			
Easy bruising			
Bleeding disorder			
Transfusions			
Do you awaken fatigued in the morning?			
Insomnia			
Hopelessness			
Crying			
Feeling blue			
Thoughts of suicide			
Nervous breakdown			
Excessive worrying			
Sexual problems			

Do you particularly want to discuss a sexual problem with your doctor? _____
Have you ever been hospitalized for emotional reasons? _____
Have you ever been to see if a psychiatrist or social worker? _____
Have you ever had x-ray therapy (not diagnostic x-rays) to your head, face or neck? _____

San Antonio Infectious Diseases Consultants (SAIDC)
Acknowledgment of Notice of Privacy Practices
Patient Financial Policy

Account#_____

We are committed to providing our patients with the highest quality care.
We thank you for taking the time to read and understand our policy.

Healthcare providers and patients each have a unique relationship with insurance carriers and different sets of responsibilities.

It is Your Responsibility:
• To know your insurance policy. You need to be aware of your benefit coverage prior to your appointment. You should obtain information from your insurance carrier regarding contracted physicians with your plan, covered and non-covered benefits, authorization requirements, and cost share information, including; deductibles, coinsurance, and co-pays. You will be held responsible for these personal balances, so it is a good idea to know your plan prior to receiving services. If you are not familiar with your plan coverage, we recommend you contact your insurance carrier directly.
• To ensure that a referral from your Primary Care Physician (PCP) has been received, and/or confirm that an authorization for treatment has been obtained from your insurance carrier, prior to receiving services, if such authorization is required. Any service subsequently found to be non-covered is your financial responsibility.
• To pay your co-pay at the time of service.
• To pay any Medicare deductible and co-insurance amounts not covered by your supplemental insurance.
• To promptly pay any patient responsibility indicated by your insurance carrier.
• To facilitate in claims payment by contacting your insurance carrier when claims are not paid in a timely manner.
• To give at least 48 hours' notice of cancellation prior to appointments. If you do not show up for an appointment and did not cancel the appointment with at least 48 hours' notice, you will be charged a $40 No-Show fee that must be paid prior to your next appointment. To understand that this charge is not reimbursable by health insurance, Medicare or Medicaid. If you consistently do not show up for appointments, or do not give adequate notice of cancellation, you may be discharged from future care with SAIDC.
• To understand that there is a $25 fee for the completion of various forms including but not limited to FMLA and disability. To also understand that this is not a charge that is reimbursable by health insurance, Medicare or Medicaid.

It is Our Responsibility:
• To provide quality medical care to all of our patients regardless of insurance coverage.
• To comply with all applicable HIPAA privacy rules, and to provide all patients with a Notice of Privacy Practices.
• To file claims with insurance companies with whom we are contracted. As a courtesy to you, we may file other commercial claims, but only with primary and secondary carriers. A 60-day period will be allowed for pending insurance payments, after which you may be held responsible for the balance.
• SAIDC cannot be responsible for providing detailed insurance coverage and benefit information to you. We are not knowledgeable about all of the many insurance plans our patients may be covered with. We will do our best to assist you with your questions; however, you should contact your insurance carrier to obtain detailed information regarding your coverage and benefits.

I have read and understood the above financial policy. I understand that I am responsible for knowing and following the guidelines of my insurance policy in order to facilitate payment for services rendered.

Patient Name (please print):	
Signature:	Date:

I acknowledge that I have been offered a copy of the SAIDC Notice of Privacy Practices.

Signature:	Date:

SAIDC Patient Portal INFORMED CONSENT FORM

SAIDC's Patient Portal is a secure messaging system between the patient and office. Messages to the patient are secure, providing HIPAA compliance that standard e-mail cannot provide.

Features of SAIDC's Patient Portal:

- View and Update personal information on file with our office
- View current statement
- View Visit Summary
- View current and upcoming appointments
- View Lab results

Instructions for Using Online Communications

You agree to take steps to keep your online communications to and from SAIDC confidential including:

Do not store messages on your employer-provided computer; otherwise personal information could be accessible or owned by your employer.

Use a screen saver or close your messages instead of leaving your messages on the screen for passersby to read and keep your password safe and private.

Do not allow other individuals or other third parties access to the computer(s) upon which you store medical communications.

Do not use email for medical communications. Standard e-mail lacks security and privacy features and may expose medical communications to employers or other unintended third parties.

Withdrawal of this Informed Consent must be done by written online communications or in writing to my office.

Charges for Using Online Communications

SAIDC may charge for certain online communications. You will be informed in advance when/if these charges apply and you will be responsible for payment of these charges if you accept and use any fee-based service. You may choose to contact your insurance carrier to determine if they cover online communications.

Conditions of Using Online Communications

The following agreements and procedures relate to online communications:

eclinicalWeb office will keep a copy of all medically important online communications in your medical record in encrypted format.

You should print or store (on a computer or storage device owned and controlled by you) a copy of all online communications that are important to you.

eClinicalWeb will not forward online communications with you to third parties except as authorized or required by law.

Online communications will be used only for limited purposes. Online communications cannot be used for emergencies or time-sensitive matters. It should be used with caution. If there is other information that you don't want transmitted via online communications, you must inform your practice. eClinicalWeb cannot be held responsible.

Please note that online communications should never be used for emergency communications or urgent requests. These should occur via telephone or using existing emergency communications tools.

eClinicalWeb is not liable for improper disclosure of confidential information

Follow-up is solely your responsibility. You are responsible for scheduling any necessary appointments and for determining if an unanswered online communication was not received.

You are responsible for taking steps to protect yourself from unauthorized use of online communications, such as keeping your password confidential. eClinicalWeb is not responsible for breaches of confidentiality caused by you or an independent third party.

I will not engage in any illegal online communications, including illegally practicing medicine across state lines.

Access to Online Communications

The following pertains to access to and use of online communications:

Online communications does not decrease or diminish any of the other ways in which you can communicate with your provider. It is an additional option and not a replacement. .

eClinicalWeb may stop providing online communications with you or change the services I provide online at any time without prior notification to you.

Risks of Using Online Communications

All medical communications carry some level of risk. While the likelihood of risks associated with the use of online communications, particularly in a secure environment, is substantially reduced, the risks are nonetheless real and very important to understand. It is very important that you consider these risks each time you plan to communicate with me, and communicate in such a fashion as to mitigate the potential for any of these risks. These risks include, but are not limited to:

Online communications may travel much further than you planned. It is easier for online communications to be forwarded, intercepted, or even changed without your knowledge.

Online communication is easier to falsify than handwritten or signed hard copies. A dishonest person could attempt to impersonate you to try to get your medical records.

It is harder to get rid of an online communication. Backup copies may exist on a computer or in cyberspace, even after you have deleted your copies.

Online communication is not private simply because it relates to your own medical information. I use a secure network to avoid using standard e-mail or e-mail systems provided by employers. Employers and online services have a right to inspect and keep online communications transmitted through their system.

Online communications are also admissible as evidence in court.

Online communications may disrupt or damage your computer if a computer virus is attached.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, as well as any other instructions that my physician may impose to communicate with patients via online communications. I have had a chance to ask any questions that I had and to receive answers. I have been proactive about asking questions related to this consent agreement. All of my questions have been answered and I understand and concur with the information provided in the answers.

Patient Name(Printed):_____

Patient Signature:_____

Date:_____

Patient (non-work) email address: _____