NEW PATIENT INFORMATION

Patient Name: ___________________________________ Date of Birth: _______________ Date: _______________

Age: _____________ Male ❑ Female ❑ Driver's License #: __________________ Social Security #: __________________

Address: ____

City: ____ State: ________________ Zip: _________________________

Home Phone: (_____)______________________________ Cell Phone: (_____)____

Employer: ____ Work Phone: (_____)_______________________________________

Referred By: ____ Primary Care Doctor: _______________________________________

Email Address: ____

IF CHILD: Legal Guardian Name(s): ____

Do you wish to receive email notifications about appointments and/or access to our patient portal: ❑ Yes ❑ No

FINANCIAL RESPONSIBILITY (*billing statements)*

Circle one: Same as Patient Different than Patient ***(If different, fill out this section)***

Name: _____________________________________ Relationship to Patient: ______________________________

Address: ____Phone: (_____)_______________________________

Date of Birth:________________________________ SS#:____

EMERGENCY CONTACT

Name: _____________________________________ Relationship to Patient: ______________________________

Address: ___________________________________ Phone: (_____)______________________________________

HOW DID YOU HEAR ABOUT US?

❑ Doctor: __________________________________

❑ Friend

❑ Ad (*which publication?):* ____________________

❑ Other

❑ Internet /Website

❑ Radio

Other Family Members Who Are HCI Patients? ❑ Yes ❑ No

Patient Name: ___________________________________ Date of Birth: _______________ Date: _______________

ACKNOWLEDGEMENTS/CONSENTS *(please initial on the line next to each section after reading)*

_____ **Receipt of *Notice of Privacy Practices***

I, *(print patient or guardian name)*____, have read a copy of Hill Country Infusion's *Notice of Privacy Practices.* (This document is available at our front desk or HillCountryInfusion.com)

_____ **Cancellation Policy**

If the patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel within 24 hours of the scheduled appointment. Hill Country Infusion reserves the right to charge the patient a $50 fee if the patient does not cancel the appointment within 24 hours.

_____ **Release of Medical Information**

I **do / do not** *(circle one)* authorize Hill Country Infusion and its designated representatives to release medical information to my spouse, parent, or guardian.

_____ **Contact Permission**

In the event that Hill Country Infusion needs to contact you (patient) regarding an appointment, lab result, medication, or any other reason, it is permissible to *(check all that apply)*:

- ☐ Leave a message on an answering machine.
- ☐ Speak with spouse / significant other. (Name:____)
- ☐ Speak with other family members. (Name(s):____)

_____ **Consent to Treatment**

I consent to the performance of those diagnostic procedures, examinations, and rendering of treatment by the medical provider and their designated office staff as is deemed necessary in the medical provider's judgement.

_____ **Authorization / Assignment / Financial Responsibility**

I authorize the release of any medical information necessary to collect payments. I understand that I am financially responsible for all charges. Should my account become a collection problem, additional charges may be incurred.

My signature below indicates that I have read and am in agreement with all statements that I have initialed above.

____ ______________________________

Signature of Patient (or Person Authorized) Date

HILL COUNTRY Infusions

NEW PATIENT INFORMATION

Patient Name: ___________________________________ Date of Birth: _______________ Date: _______________

MAIN REASON(S) FOR TODAY'S VISIT

What is the main reason(s) for today's visit? ____

____

When was the first time you had this problem? ____

When did this episode start? _________________________ How often do episodes recur? ______________________________

What time of day are symptoms worse? *(circle)* morning noon afternoon nighttime all the time anytime

During which months is it most severe? *(circle)* Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec all year

Are symptoms worse in certain locations? *(circle)* home work outside indoors other ____________________

Suspected causes: *(circle)* trees weeds grass mold dust perfumes scents heat cold weather changes

smoke stress cats dogs other animals_______________ foods_________________ other_____________

How long have you lived in this area? _____________________ Moved from where? __________________________________

Where did you grow up? ________________________________

REVIEW OF SYMPTOMS *(Circle any current symptom(s)/description(s) that applies or circle "NS" if you have no symptoms)*

General healthy fever chills night sweats body aches fatigue malaise weight loss weight gain

Nose NS congestion decreased sense of smell post nasal drip nasal discharge (runny/thick/clear/discolored) sneezing snorting rubbing bleeds

Sinus NS infections (past/constant/frequent/occasional) pressure drainage

Ears NS infections (past/constant/frequent/occasional) pressure popping discharge earache hearing loss

Eyes NS itchy watery red burning dry swollen eyelids puffy dark circles under eyes

Mouth NS bad breath gum problems lip swelling pain in teeth grinding itching ulcers tongue swelling

Throat NS difficulty swallowing sore clearing snoring hoarseness loss of voice post nasal drip swelling

GI NS heartburn vomiting nausea diarrhea constipation cramping bloating

Chest NS tightness pain palpitations heaviness pressure congestion cramping bloating

Wheezing NS daily frequent occasional rare associated with illness/exercise

Coughing NS constant/frequent/occasional dry deep hacking gasping turning blue productive of mucus

Shortness of Breath NS constant/frequent/occasional nighttime with exercise with normal activity at rest

Urinary NS frequency urgency burning pain difficulty urinating

Joints NS swollen painful

Skin NS itching dry rash hives blistering swelling

Neuro NS dizziness lightheaded sleep disturbance anxiety depressed passing out numbness tremor

Headache NS
- **Frequency**: constant frequent occasional rare
- **Severity**: incapacitating severe moderate minor
- **Nature**: throbbing dull stabbing
- **Location**: L/R sided top/back of head between/behind eyes temples forehead
- **Symptoms**: sound sensitivity light sensitivity nausea vomiting visual changes pain in teeth

HILL COUNTRY Infusions

NEW PATIENT INFORMATION

Patient Name: ___________________________________ Date of Birth: _______________ Date: _______________

MEDICATION/MEDICAL HISTORY

1. Current Medications *(prescription, non-prescription, herbal, vitamins, creams, sprays, pills, liquids, drops):*

   1.______________________________ 4.______________________________ 7.______________________________

   2.______________________________ 5.______________________________ 8.______________________________

   3.______________________________ 6.______________________________ 9.______________________________

2. Have you ever been prescribed an **EpiPen** (adrenalin/epinephrine)? Y N If yes, for:__________________________
3. What medications have been HELPFUL now or in the past? ____
4. What medications have been UNHELPFUL? ____
5. Drug Allergy/Intolerance: *Describe when/what reaction occurred or (circle)* ***None Known****:*

   1.______________________________ ____

   2.______________________________ ____

   3.______________________________ ____

6. Your preferred pharmacy and location? ____
7. Hospitalizations / Surgical Operations (include dates):

   1.____ 4. ____

   2. ____ 5. ____

   3. ____ 6. ____

8. Other problems? *(please circle any that you have now or have had in the past)*

High blood pressure	Reflux	Thyroid problems	Heart attack
Hiatal hernia	Kidney problems	Stroke	Diabetes
Chronic infections	Glaucoma	Emphysema	Skin problems
Cataracts	History of asthma	Lupus/other Autoimmune	Depression
Gout	Liver problems	Bipolar	Arthritis
Cancer of ________________	ADD/ADHD	Fibromyalgia	Bleeding problems
Osteoporosis/osteopenia	HIV	Hepatitis A, B or C	HSV
Tuberculosis	Other:____________________________		

ENVIRONMENTAL / SOCIAL HISTORY

1. Occupation / grade in school / daycare ____
2. Hobbies: ____
3. **IF CHILD:** full term premature *(how early?)*_________ birth weight__________ Delivery: vaginal caesarean adopted

   Complications: before during after birth? Y N If yes, what? ____

   Who has legal custody?__________________________ With whom does child live?___________________________________

Patient Name: __________________________________ Date of Birth: ______________ Date: ______________

4. Vaccinations current? Y N **Flu vaccine :** Yr:________Mo:_______ **Pneumococcal vaccine** *(65 or older)* Yr:________Mo:______
5. Personal tobacco use (cigarette/chew/pipe/snuff/e-cig): Never Former Current
   If yes, how many years?__________ frequency? Some Days or Every Day packs per day?____________
6. Alcohol use: How often in the last year have you had a drink *(circle one)*: Never ≤Monthly 2-4/Month 2-3/Week ≥4/Week
   When drinking, typical # of drinks per day *(circle one)*: 1-2 3-4 5-6 7-9 ≥10
   # of times in the past year ≥6 drinks per day *(circle one)*: Never Less than Monthly Monthly Weekly Daily
7. Recreational drug use: Never Former Current If yes, what? ____
8. Any increased **HIV** or **HSV** risk factors? Y N Not Sure
9. Pets (type/number)____ how long?_________________________
   Where do they stay? inside outside both in bedroom Do you have increased allergy symptoms around animals? Y N
10. Home: Age of building__________________ water damage/leaks visible mold/musty odor
    Please circle appropriate responses below:
    Flooring: carpet tile hardwood throw rugs other_____________________________
    Bedroom: box spring/mattress waterbed stuffed chair/couch throw pillows down pillows and/or comforter tapestries
    Window coverings: cloth roll shades shutters wood/metal/plastic blinds
    Fans: not used yes, in rooms
    Air conditioning: central window units
11. Workplace/Home/School Exposure: mold animals chemicals metals paint fumes smoke other__________________

INFLAMMATION HISTORY

1. Have you ever been tested for allergies/Inflamation? Y N ***(If "no", please skip to question 7 in this section)***
2. Describe the nature of the inflammatory symptoms you have ____
   ____
3. What kind of work up have you had before? ____
4. Where can we obtain your test results? ____
5. What working diagnoses were you given? ____
6. Did you get any specific treatments? Y N If yes, how long ago and what kinds of treatments? ____________________
   ____
7. Food & Chemical allergy/intolerance: D*escribe when/what reaction occurred or (circle)* ***None Known****:*
   1.______________________________ ____
   2.______________________________ ____
   3.______________________________ ____