Dr. Maria Salinas
1770 State Hwy 46 W
New Braunfels, TX 78132
Ph: 830-631-8182 option 4
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NEW PATIENT QUESTIONNAIRE

Please fill out this form as thoroughly as possible, printing all responses clearly. All information is completely confidential and will not be released unless you authorize us to do so.

PERSONAL INFORMATION **Please provide a form of identification (Driver's License)						
Last Name	First	Middle	Prefix	Birthdate	Sex M	Sex F
Mailing Address	City	State	Zip	Social Security Number		
Home/Mobile Phone	Email Address					
Emergency Contact	Relationship	Home/Mobile Phone	Work Phone			
Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed		Number of Children:	Occupation:			

INSURANCE INFORMATION IF DIFFERENT FROM ABOVE **Please provide a copy of the Insurance Card(s)			
Name of Person Responsible for Insurance Account:		Relation to Patient:	Insurance Company(ies)
Birthdate:	Soc. Sec. Number:	Insurance Member ID #	Insurance Group #

MEDICAL HISTORY ***Check conditions you have or have had in the past***			
□ Anemia	□ Crohn's Disease or Colitis	□ Heart Problem:	□ Osteoarthritis
□ Anxiety Disorder	□ Depression	□ Hepatitis or Liver Disease	□ Osteoporosis
□ Arthritis	□ Diabetes	□ High Blood Pressure	□ Pneumonia
□ Asthma	□ Emphysema	□ High Cholesterol	□ Psoriasis
□ Ankylosing Spondylitis	□ Epilepsy	□ HIV/AIDs	□ Pulmonary Embolism
□ Blood Clots	□ Glaucoma	□ Jaundice	□ Rheumatic Fever
□ Cancer type: _____	□ Goiter	□ Kidney Disease	□ Rheumatoid Arthritis
□ Cataracts	□ Gout	□ Leukemia	□ Stomach Ulcer
□ Congestive Heart Failure	□ Headaches	□ Lupus or SLE	□ Stroke
□ COPD	□ Heart Attack	□ Lymphoma	□ Tuberculosis

REVIEW OF SYSTEMS ***Select condition(s) you are currently experiencing***							
Weight loss	Weight gain	Easy bruising	Fatigue	Joint pain	Tremor	Sleep disorder	Fevers or Chills
Excessive thirst	Headaches	Chest pain	Dizziness	Muscle pain	Hoarseness	Constipation	Diarrhea
Frequent Falls	Palpitations	Blurred vision	Joint Swelling	Eye Pain	Weakness	Nausea vomiting	Stiffness
Ringing in ears or trouble hearing	Shortness of breath or cough	Night sweats or Flushing	Sexual issues (loss of interest or erections)	Numbness or tingling	Depression or Anxiety	Difficulty with urination	Difficulty swallowing

For Women: Age at first period: _____ Date of last period: _____ Birth control method: _____
Pregnancies: Live Births: ___ Miscarriages: ___ Abortions: ___ Are you planning to have more pregnancies? □ Yes □ No

Primary Care Physician:	**Other Physicians:**
Reason for Visit:	

Patient Name: _____ DOB: _____

ALLERGIES	
No Known Allergies	Yes, I have the following medication allergies and the following reaction:

HOSPITALIZATIONS & SURGERIES		
YEAR	LOCATION	REASON FOR HOSPITALIZATION / DESCRIBE SURGERIES

MEDICATIONS ***List all medications, vitamins, and supplements. Write dosage and frequency for each medication. *Please attach additional sheets if necessary.***

Preferred Pharmacy & Address:	Phone:
Secondary Pharmacy & Address:	Phone:

Immunizations and Testing			
Influenza Injection: Y/N	Date:	Last Eye Exam	Date:
Pneumonia Injection: Y/N	Date:	Last Tuberculosis Test	Date:
Tdap/Tetanus Injection: Y/N	Date:	Last Bone Density Scan	Date:
Hepatitis B Injection: Y/N	Date:	Last Chest X-Ray	Date:
Hepatitis A Injection: Y/N	Date:	Last Mammogram	Date:

Family Medical History ***Check appropriate medical conditions***	
Father Alive: Y/N	
Mother Alive: Y/N	
Brother Alive: Y/N	
Sister Alive: Y/N	
Other Family	

Social History ***Mark (X) conditions you use and how much/how many hours***					
	Tobacco use:		Alcohol use:		Diet:
	Illegal drug use:		Exercise:		Sleep:
	Caffeine intake:		Level of Stress:		Hobbies:

**** Please review our Clinical Policies and Agreements****

Your signature below signifies that you have read and acknowledge the policies regarding:

1) Consent for Treatment
2) Financial Responsibility
3) Release of Information
4) Benefit Assignment
5) About Physician Assistants
6) Acknowledgement
7) Notice of Privacy Practices

I attest that the above information is correct to the best of my knowledge.

I also certify that I, and/or my dependent(s), have insurance coverage with the insurance(s) provided and assign all insurance benefits, if any, directly to the Zenith Integrated Specialist. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The clinicians assigned to the Zenith Integrated Specialist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below:

_____

Signature of Patient, Parent, Guardian, or Personal Representative Date

_____

Printed name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

Consent for Release of Protected Health Information (PHI)

This form is used to authorize consent for this clinician and its affiliates to communicate PHI to the person(s) or organization listed below as directed by the patient.

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Patient Email address: _____

Home Phone: _____ Cell Phone: _____

1) Information may be disclosed and used by the listed person(s) or organization(s) to assist me:
Name:_____

Relationship: □ Spouse □ Sibling □ Parent □ Child □ Agent/Broker □ Friend □ Organization

2) Information may be disclosed and used by the listed person(s) or organization(s) to assist me:
Name:_____

Relationship: □ Spouse □ Sibling □ Parent □ Child □ Agent/Broker □ Friend □ Organization

3) Information may be disclosed and used by the listed person(s) or organization(s) to assist me:
Name: _____

Relationship: □ Spouse □ Sibling □ Parent □ Child □ Agent/Broker □ Friend □ Organization

I understand that this consent will allow this healthcare clinician and its affiliates to use or disclose the protected health information described below. (Please check only one box).

□ Full Disclosure: Any protected health information this provider and its affiliates collect and maintain, including mental health, HIV, sexually transmitted diseases, health status, alcohol and substance abuse treatment records, and genetic testing. This also includes information on health treatment programs, plan information and caregiver resources with the person being authorized.

□ Limited Disclosure: **Identify what protected health Information is to be excluded from any disclosure**. Such as a medical condition or treatment information or a specific date range of services:

_____

I understand:

- **This consent will expire in 24 months from the date of signature, unless I cancel it before that time. I can cancel this consent at any time by sending a written request to my provider.**
- **If I cancel the consent, it will not apply to information previously released with this consent. Once information is shared, this provider cannot prevent the person or organization that has access to it from sharing that information with others, and this information may not be protected by federal privacy regulations.**
- **I understand I am not required to sign this consent and that this provider and its affiliates cannot base treatment or payment decisions based on my decision to sign this consent form.**
- **Protected Health Information includes Medical, Dental, Pharmacy, Behavioral Health, Vision, and Long-Term Care.**

Individual or Legal Representative Signature _____ Date: _____

□ Individual □ Legal Representative (attach copy of authorization, i.e. MPOA, guardianship)

ZENITH
Integrated Specialists

NO SHOW/CANCELLATION POLICY

Welcome to Zenith Integrated Specialist! We are delighted you have chosen our practice to provide you with your health care.

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That is why it is especially important that you keep your scheduled appointment with us and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, Zenith Integrated Specialist sends text messages and phone call reminders.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with a physician, please give us at least 24-hour notice.

If you do not cancel or reschedule your appointment with at least 24-hour notice, we may assess a $100 “no-show” service charge to your account. This “no-show charge” is not reimbursable by your insurance company. You will be billed directly for it.

I understand that I must cancel or reschedule any appointment at least 24 hours in advance in order to avoid a potential no-show charge.

_____ _____

Signature of patient/responsible party Date

_____

Printed name

Authorization to Disclose (Release) Health Care Information

1. Patient Information:
   PRINT Patient Name: _____
   Birth Date _____
   Address: _____
   City, State, Zip Code: _____
   Telephone Number: _____

2. INFORMATION TO BE RELEASED TO: [ ] Check if the same as 1 above
   Organization: **Zenith Integrated Specialist-Dr. Maria Salinas, Rheumatology**
   Address: **1770 State Hwy 46 West Ste 1205**
   City, State, Zip: **New Braunfels, TX 78132**
   Phone: **(830) 631-8182** Fax: **(830) 730-4203**

3. INFORMATION TO BE RELEASED FROM:
   Organization, physician, or provider: _____
   Address: _____
   City, State, Zip: _____
   Phone: _____ Fax: _____

4. PURPOSE OF RELEASE
   [ ]Transfer of Care [ ]Legal [ ]Insurance [ ]Specialist [ ]Personal copy [ ]Other _____

5. WHAT KIND OF INFORMATION DO YOU WANT RELEASED:
   [ ] Copies of All Records
   [ ] Medical Records from ___/ ___ /___ to date: ___/___ /___
   [ ] Specific Information (please specify): _____
   [ ] Billing Records (please specify): _____
   [ ] Diagnostic Reports (please specify): _____

PATIENT AUTHORIZATION: I understand that:

a. Information released may include information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental/psychiatric illness and for patients age 13-17, information regarding reproductive care. I give my specific authorization for this information to be released.

b. Generally, Zenith Integrated Specialist and any other entity covered by the Health Insurance Portability and Accountability Act of 1996, may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. If this authorization is for purposes of determining enrollment, eligibility, underwriting or risk rating prior to enrollment, not signing or revoking this authorization may impact enrollment or benefit determinations by Zenith Integrated Specialist.

c. I may revoke this authorization in writing. If I revoke my authorization, it will not affect any actions already taken based upon this authorization. Once disclosed, health care information may be subject to redisclosure by the recipient and may no longer be protected under health information privacy laws.

d. This authorization expires 90 days from the date signed OR on this date: _____

SIGNATURE: _____ DATE: ____/___/___
(Patient or Member, Guardian, or Authorized Representative).

MINOR SIGNATURE: _____ DATE: ____/___/___
(Signature of minor ages 13-17 is required to release information listed above)