# Medical Center West

**Dr.Michelle Berry  Kelle Pardi MSN,FNP-C**
*1201 S. Main St, Ste. 110 Boerne, TX 78006  830-249-6000 phone*

## Registration Form

| Last Name | First Name | MI | DOB | Account Number (Office use only) |
|---|---|---|---|---|
| | | | | |

| Street Address | City | State | ZIP Code |
|---|---|---|---|
| | | | |

| Home Phone | Work Phone | Cell Phone | Social Security # |
|---|---|---|---|
| | | | |

| Email Address |
|---|
| |

| Emergency Contact | Contact Phone |
|---|---|
| | |

| PRIMARY Insurance Name | Copay $ | SECONDARY Insurance Name | Copay $ |
|---|---|---|---|
| | | | |

| Claims Address | Claims Address |
|---|---|
| | |

| City, State, ZIP | City, State, ZIP |
|---|---|
| | |

| Subscriber's Name | Subscriber DOB | Subscriber's Name | Subscriber DOB |
|---|---|---|---|
| | | | |

| Subscriber's ID No. | Group No. | Subscriber's ID No. | Group No. |
|---|---|---|---|
| | | | |

| Patient's Relation to Subscriber | Patient's Relation to Subscriber |
|---|---|
| ☐ Self ☐ Spouse ☐ Child ☐ Other | ☐ Self ☐ Spouse ☐ Child ☐ Other |

**How did you hear about our practice?**
☐ Family ☐ Friend ☐ Newspaper ☐Radio ☐ TV ☐ Phone Book ☐ HFP Website
☐ Internet ☐ Signage ☐ Insurance Directory ☐ Other Physician ☐ Hospital

**Please provide the following information so we may improve patient communication and care.**

**Primary Language** *(select one)*
☐ English ☐ Arabic ☐ Bengali ☐ Chinese ☐ German ☐Hindi (Urdu)
☐ Japanese ☐ Mandarin ☐ Portuguese ☐ Russian ☐ Spanish

**Ethnicity**
☐ Hispanic or Latino
☐ NOT Hispanic or Latino

**Race**
☐ American Indian or Alaska Native ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Asian

**Complete this section ONLY if the patient is under 18 years old.**

| Last Name | First Name | Relationship to Patient |
|---|---|---|
| | | |

| Street Address | City | State | ZIP Code |
|---|---|---|---|
| | | | |

| Home Phone | Work Phone | Cell Phone | Gender |
|---|---|---|---|
| | | | |

**The undersigned patient or individual acting on behalf of the patient agrees that the above facts are correct.**

**Signature**_____ **Date**_____

# Health Risk Assessment

Date: _____

Name: _____ DOB: _____ ❑Male ❑Female
First Last M.

**Please complete this questionnaire prior to your visit and bring with you.**
*Your responses will help your care team and physician provide you with a thorough wellness visit.*

1. **Do you use tobacco?** ❑Yes ❑No | Former Smoker? ❑Yes ❑No

❑Cigarettes: packs per day # ____ or cigarettes per day # ____ **❑I would like information to quit**

❑Cigar: per day # ____ ❑Pipe: per day # ____

❑Chewing Nicotine containing Tobacco Substances

2. **During the last 4 weeks, on average, how many drinks of wine, beer, or other alcoholic beverages did you have?**

❑Drinking in Moderation (2 drinks/day or fewer)
❑Wine Consumption #____ Glasses per Day
❑Beer Consumption #____ Servings per Day
❑Hard Liquor Consumption #____ Servings per Day
❑Never Drink Alcohol
❑Stopped Drinking Alcohol

3. **Do you currently use recreational or street drugs?** ❑Yes ❑No ❑Never used drugs
If yes, what type of drug? _____

4. **Choose the best description(s) of your current diet:**

❑Diet Well Balanced ❑Diet Not Balanced
❑High in Fat Content (Fried Foods or Fast Foods)
❑Low in Fat Content
❑High in Sugar (Sweet Snacks or High Sugar Beverages)
❑Diet High in Fiber
❑Carbohydrate Intake Excessive
❑Diet is Low in Sugar
❑Diet is High in Salt

5. **Do you exercise?** ❑Yes ❑No If yes, how many minutes per weeks? _____

❑Walk ❑Run ❑Bicycle ❑Swim ❑Aerobics ❑Stretching/Yoga

❑Strength Training ❑Other _____

6. **During the past two weeks have you felt down, depressed or hopeless?** ❑ Yes ❑ No

**Over the past two weeks, have you felt little interest or no pleasure in doing things?** ❑ Yes ❑ No

Continued →

Name: _____ DOB: _____
First Last M.

7. **Do you need help with any of the following?**

| | | |
|---|---|---|
| ❑Using the phone | ❑Managing medications | ❑Feeding |
| ❑Shopping | ❑Transportation | ❑Dressing |
| ❑Housework | ❑Preparing meals | ❑Toileting |
| ❑Doing laundry | ❑Managing money | ❑Grooming/Bathing |

8. **Do you have vision loss that concerns you?** ❑Yes ❑No

9. **Have you fallen two or more times in the last past year?** ❑Yes ❑No

10. **Are you having difficulties driving your car?** ❑Yes, often ❑Sometimes ❑No ❑I do not drive

11. **Do you always fasten your seat belt when your in a car?** ❑Yes ❑No

12. **Do you have trouble hearing?** ❑Yes ❑No **Do you use a hearing aid?** ❑Yes ❑No

13. **Does your home contain any of the hazards that may hurt you?**

| | |
|---|---|
| ❑Loose rugs | ❑Uneven floors |
| ❑Household clutter | ❑Missing bathroom grab bars |
| ❑Poor lighting | |
| ❑Loose or missing stair handrails | |

14. **Do you have any Advance Directives in place?**
- ❑None
- ❑Health Care Power of Attorney
- ❑Living Will
- ❑I would like information on Advance Directives

15. **Please list specialist and suppliers regulary involved in providing you with medical care.**

| | | | |
|---|---|---|---|
| ❑ Cardiologist | _____ | ❑ Diet/Nutrition | _____ |
| ❑ Endocrinologist | _____ | ❑ Medical Equipment | _____ |
| ❑ Gastroenterologist | _____ | ❑ Home Health | _____ |
| ❑ Nephrologist | _____ | ❑ Occupational Therapy | _____ |
| ❑ Neurologist | _____ | ❑ Physical Therapy | _____ |
| ❑ Oncologist | _____ | | |
| ❑ Ophthalmologist | _____ | ❑ Other | _____ |
| ❑ Orthopedic | _____ | | _____ |
| ❑ Pulmonologist | _____ | | _____ |

*Thank you very much for completing your Health Risk Assessment form for your wellness visit.*
*Please give this form to your care team during your visit.*

# HEALTH HISTORY QUESTIONNAIRE

Please complete this entire questionnaire. It will provide your care team with important information about your health.
All answers contained in this questionnaire are strictly confidential and will become part of your medical record.

**Name** *(Last, First, M.I.)*:_____ ☐ M ☐ F **DOB:**_____

**Date:**_____ **Marital status:** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

**Number of children:**_____ **How many live with you?**_____ **Occupation is/was:**_____

**Previous or referring doctor:**_____ **Date of last physical exam:**_____

## PERSONAL HEALTH HISTORY

**Childhood Illness:** ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ None

**Immunizations and Dates:** ☐ Tetanus_____ ☐ Pneumonia_____ ☐ Hepatitis A_____ ☐ Hepatitis B_____

☐ Chickenpox_____ ☐ Influenza_____ ☐ MMR *Measles, Mumps, Rubella*_____ ☐ Meningococcal_____ ☐ None

**Tests/Screenings and Dates:** ☐ Eye Exam_____ ☐ Colonoscopy_____ ☐ Dexa Scan_____

**Surgeries**

Year_____ Reason_____ Hospital_____

Year_____ Reason_____ Hospital_____

Year_____ Reason_____ Hospital_____

Year_____ Reason_____ Hospital_____

☐ I have had no surgeries

**Other hospitalizations**

Year_____ Reason_____ Hospital_____

Year_____ Reason_____ Hospital_____

Year_____ Reason_____ Hospital_____

Year_____ Reason_____ Hospital_____

☐ I have never been hospitalized

**Have you ever had a blood transfusion?** ☐ Y ☐ N

**Please list other physicians you have seen in the last 12 months, and for what reason.**

_____

_____

_____

_____

_____

Name (Last, First, M.I.):_____ DOB _____

## YOUR MEDICAL HISTORY

Please indicate if **YOU** have a history of the following:

- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anesthetic Complication
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Problems
- ☐ Birth Defects
- ☐ Bladder Problems
- ☐ Bleeding Disease
- ☐ Blood Clots
- ☐ Blood Transfusion(s)
- ☐ Bowel Disease
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Colon Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Growth/Development Disorder
- ☐ Hearing Impairment
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Pain/Angina
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ H IV
- ☐ Hives
- ☐ Kidney Disease
- ☐ Liver Cancer
- ☐ Liver Disease
- ☐ Lung Cancer
- ☐ Lung/Respiratory Disease
- ☐ Mental Illness
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Prostate Cancer
- ☐ Rectal Cancer
- ☐ Reflux/GERD
- ☐ Seizures/Convulsions
- ☐ Severe Allergy
- ☐ Sexually Transmitted Disease
- ☐ Skin Cancer
- ☐ Stroke/CVA of the Brain
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Ulcer
- ☐ Visual Impairment
- ☐ Other Disease, Cancer, or Significant Medical Illness
- ☐ NONE of the Above

**List other past medical problems:**_____

_____

_____

**List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers**

Drug _____ Dose/Frequency_____ Drug_____ Dose/Frequency _____

Drug _____ Dose/Frequency_____ Drug_____ Dose/Frequency _____

Drug _____ Dose/Frequency_____ Drug_____ Dose/Frequency _____

Drug _____ Dose/Frequency_____ Drug_____ Dose/Frequency _____

☐ List additional drugs on back of questionnaire

☐ I take no medications, vitamins, herbals, or any other over-the-counter preparations

**Allergies**

Name_____ Reaction You Had _____

☐ I have no known **drug** allergies

## FAMILY MEDICAL HISTORY

Please indicate if **YOUR FAMILY** has a history of the following: ***(ONLY** include parents, grandparents, siblings, and children)*

☐ I am adopted and do not know biological family history

- ☐ Family History Unknown
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anesthetic Complication
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder Problems
- ☐ Bleeding Disease
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Lung/Respiratory Disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Other Cancer
- ☐ Rectal Cancer
- ☐ Seizures/Convulsions
- ☐ Severe Allergy
- ☐ Stroke/CVA of the Brain
- ☐ Thyroid Problems
- ☐ NONE of the Above
- ☐ Mother, Grandmother, or Sister developed heart disease before the age of 65
- ☐ Father, Grandfather, or Brother developed heart disease before the age of 55

Name (Last, First, M.I.):_____ DOB _____

# SOCIAL HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL

**Exercise** Do you exercise? ☐ Y ☐ N

If yes, how many minutes per week?_____

**Diet** Are you dieting? ☐ Y ☐ N If yes, are you on a physician prescribed medical diet? ☐ Y ☐ N

# of meals you eat in an average day?_____

Rank salt intake ☐ Hi ☐ Med ☐ Low

Rank fat intake ☐ Hi ☐ Med ☐ Low

**Caffeine** ☐ None ☐ Coffee ☐ Tea ☐ Cola # of cups/cans per day?_____

**Alcohol** Do you drink alcohol? ☐ Y ☐ N

If yes, what kind?_____ How many drinks per week?_____

Are you concerned about the amount you drink? ☐ Y ☐ N

Have you considered stopping? ☐ Y ☐ N

Have you ever experienced blackouts? ☐ Y ☐ N

Are you prone to "binge" drinking? ☐ Y ☐ N

Do you drive after drinking? ☐ Y ☐ N

**Tobacco** Do you use tobacco? ☐ Y ☐ N

☐ Cigarettes – pks./day_____ **or** pks./week _____ ☐ Chew - #/day_____ ☐ Pipe - #/day_____ ☐ Cigars - #/day_____

☐ # of years_____ ☐ Previous tobacco user - year quit _____

**Drugs** Do you currently use recreational or street drugs? ☐ Y ☐ N

Have you ever given yourself street drugs with a needle? ☐ Y ☐ N

☐ I prefer to discuss with the physician

**Sex** Are you sexually active? ☐ Y ☐ N

If yes, are you and your partner trying for a pregnancy? ☐ Y ☐ N

If not trying for a pregnancy list contraceptive or barrier method used:_____

Any discomfort with intercourse? ☐ Y ☐ N

Illness related to Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? ☐ Y ☐ N

**Mental Health** Is stress a major problem for you? ☐ Y ☐ N

Do you feel depressed? ☐ Y ☐ N

Do you panic when stressed? ☐ Y ☐ N

Do you have problems with eating or your appetite? ☐ Y ☐ N

Do you cry frequently? ☐ Y ☐ N

Have you ever attempted suicide? ☐ Y ☐ N

Have you ever seriously thought about hurting yourself? ☐ Y ☐ N

Do you have trouble sleeping? ☐ Y ☐ N

Have you ever been to a counselor? ☐ Y ☐ N

Name (Last, First, M.I.):_____ DOB _____

## Personal Safety

Do you live alone? ☐ Y ☐ N

Do you have frequent falls? ☐ Y ☐ N

Do you have vision or hearing loss? ☐ Y ☐ N

Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? ☐ Y ☐ N

How often do you have sun exposure? ☐ Occasionally ☐ Frequently ☐ Rarely

Have you ever experienced a sunburn? ☐ Y ☐ N

How often do you wear your seatbelt? ☐ Occasionally ☐ Frequently ☐ Always

### These questions are for WOMEN ONLY

Age at onset of menstruation:_____ Date of last menstruation:_____ Period every_____days

Heavy periods, irregularity, spotting, pain, or discharge? ☐ Y ☐ N

Number of pregnancies:_____ Number of live births:_____

Are you pregnant or breastfeeding? ☐ Y ☐ N

Have you had a D&C, hysterectomy, or Cesarean? ☐ Y ☐ N

Any urinary tract, bladder, or kidney infections within the last year? ☐ Y ☐ N

Any blood in your urine? ☐ Y ☐ N

Any problems with control of urination? ☐ Y ☐ N

Any hot flashes or sweating at night? ☐ Y ☐ N

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? ☐ Y ☐ N

Do you perform monthly breast self exams? ☐ Y ☐ N

Experienced any recent breast tenderness, lumps, or nipple discharge? ☐ Y ☐ N

Date of last mammogram:_____ Where was the mammogram done? _____

Date of last papsmear or pelvic exam:_____

### These questions are for MEN ONLY

Do you usually get up to urinate during the night? ☐ Y ☐ N

Do you feel pain or burning with urination? ☐ Y ☐ N

Any blood in your urine? ☐ Y ☐ N

Do you feel burning discharge from penis? ☐ Y ☐ N

Has the force of your urination decreased? ☐ Y ☐ N

Have you had any kidney, bladder, or prostate infections within the last 12 months? ☐ Y ☐ N

Do you have any problems emptying your bladder completely? ☐ Y ☐ N

Any difficulty with erection or ejaculation? ☐ Y ☐ N

Any testicle pain or swelling? ☐ Y ☐ N

Date of last prostate and rectal exam:_____

Name (Last, First, M.I.):_____ DOB _____

## Other Information

**Your healthcare provider needs to know:**

Do you have Advanced Directives? *(Advance Directives refer to a person's instructions about future medical care, in the event the person becomes unable to speak for himself/herself. A Living Will is an example of an Advance Directive.)*..... ☐ Y ☐ N

If no, would you like additional details about Advanced Directives? ..... ☐ Y ☐ N

Do you have any religious or cultural beliefs that may impact your healthcare? ..... ☐ Y ☐ N

If yes, please describe:_____

I best learn new information by: ☐ Verbal instructions ☐ Written instructions ☐ Pictures

Level of education completed: ☐ Less than High School ☐ High School diploma or GED ☐ 1-4 years of college ☐ > 4 years of college

I understand English well? ☐ Y ☐ N If no, what language do you prefer?_____

**Please circle any symptoms you are currently experiencing or symptoms you have frequently experienced in the past.**

| | | | |
|---|---|---|---|
| Fever<br>Chills | Feeling poorly<br>Feeling tired/fatigued | Recent weight gain<br>Recent weight loss | |
| Eye pain<br>Red eyes | Eyesight problems<br>Discharge from eyes | Dry eyes<br>Eyes itch | Vision changes |
| Earache<br>Loss of hearing | Nosebleeds<br>Discharge from nose | Sore throat<br>Hoarseness | Ringing in ears<br>Sinus problems |
| Chest pain<br>Palpitations | Fast/slow heartbeat<br>Cold hands/feet | Muscle pain<br>Swelling in legs | History of heart murmur<br>History of heart attack |
| Shortness of breath<br>Wheezing | Cough<br>Shortness of breath with activity | Difficulty breathing while lying down/sleeping | Coughing up phlegm/blood |
| Abdominal pain<br>Vomiting | Constipation<br>Diarrhea | Heartburn<br>Black, tarry stools | Blood per rectum |
| Pain with urination<br>Urinary incontinence | Frequent urination at night | | Urinary frequency |
| Muscle/joint pain | Joint swelling<br>Joint stiffness | Limb pain | Back pain |
| Skin lesions<br>Skin wound | Itching<br>Change in mole | | Nail discoloration/deformity |
| Confusion<br>Convulsions/seizures | Dizziness<br>Fainting | Limb weakness<br>Difficulty walking | Numbness/tingling<br>Frequent falls |
| Suicidal<br>Sleep disturbances | Anxiety<br>Depression | Change in personality<br>Emotional problems | |
| Decreased libido/sexual desire | | Deepening of voice | Hair loss |
| Easy bleeding or bruising | Swollen glands | | |

**Other symptoms:** _____

_____

Patient's Signature:_____ Date:_____

Reviewed By:_____ Date:_____

# CANCER FAMILY HISTORY QUESTIONNAIRE

## Personal Information

**Patient Name:** _____ **Date of Birth:** _____ **Age:** _____

**Gender (M/F):**_____ **Today's Date(MM/DD/YY):**_____ **Health Care Provider:**_____

**Instructions:** This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

**You and the following close blood relatives should be considered:** *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren*

## YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

| | CANCER | YOU AGE OF Diagnosis | PARENTS / SIBLINGS / CHILDREN | AGE OF Diagnosis | RELATIVES on your MOTHER'S SIDE | AGE OF Diagnosis | RELATIVES on your FATHER'S SIDE | AGE OF Diagnosis |
|---|---|---|---|---|---|---|---|---|
| ☑Y ☐N | *EXAMPLE: BREAST CANCER* | *45* | *—* | *—* | *Aunt Cousin* | *45 61* | *Grandmother* | *53* |
| ☐Y ☐N | BREAST CANCER *(Female or Male)* | | | | | | | |
| ☐Y ☐N | OVARIAN CANCER *(Peritoneal/Fallopian Tube)* | | | | | | | |
| ☐Y ☐N | UTERINE (ENDOMETRIAL) CANCER | | | | | | | |
| ☐Y ☐N | COLON/RECTAL CANCER | | | | | | | |
| ☐Y ☐N | 10 or more LIFETIME COLON POLYPS *(Specify #)* | | | | | | | |
| ☐Y ☐N | OTHER CANCER(S) *(Specify cancer type)* | Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach (Gastric), Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid, Prostate* | | | | | | |

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

## Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

### Hereditary Breast and Ovarian Cancer Syndrome - Red Flags*

***Personal and/or family history† of:***

- ☐ Breast cancer diagnosed before age 50
- ☐ Ovarian cancer
- ☐ Two primary breast cancers
- ☐ Male breast cancer
- ☐ Triple Negative Breast Cancer
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer‡§
- ☐ Three or more HBOC-associated cancers at any age‡§
- ☐ A previously identified HBOC syndrome mutation in the family

*†Close blood relatives include first-, second-, or third-degree in the maternal or paternal lineage*
*‡In the same individual or on the same side of the family*
*§HBOC-associated cancers include breast (including DCIS), ovarian, pancreatic, and aggressive prostate cancer*

### Lynch Syndrome - Red Flags*

***An individual with any of the following:***

- ☐ Colorectal or endometrial cancer before age 50
- ☐ MSI High histology before age 60¶
- ☐ Abnormal MSI\IHC tumor test result (colorectal/endometrial)
- ☐ Two or more Lynch syndrome cancers** at any age
- ☐ Lynch syndrome cancer** with one or more relatives with a Lynch syndrome cancer^
- ☐ A previously identified Lynch syndrome or MAP syndrome mutation in the family

***An individual with any of the following family histories:***

- ☐ A first- or second-degree relative with colorectal or endometrial cancer before age 50
- ☐ Two or more relatives with a Lynch syndrome cancer**, one before the age of 50^
- ☐ Three or more relatives with a Lynch syndrome cancer** at any age^
- ☐ A previously identified Lynch syndrome or MAP syndrome mutation in the family

*¶MSI High histology includes: Mucinous, signet ring, tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, or medullary growth pattern*
***Lynch syndrome-associated cancers include colorectal, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas*
*^Cancer history should be on the same side of the family*

**Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com*

## Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature:_____ Date: _____

Health Care Provider's Signature: _____ Date: _____

**For Office Use Only:** Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment:_____

MEDICAL CENTER WEST
Dr. Michelle D. Berry

1201 S. MAIN STREET, STE. #110
BOERNE, TEXAS 78006

830-249-6000 (OFFICE)
830-816-6002 (FAX)

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

*Patient Name:*_____ *Date of Birth:*_____
*Address:*_____ *Telephone #:*_____
_____ *Date of Service:* _____*ALL*_____

## INFORMATION REQUESTED

| | | |
|---|---|---|
| ___ Entire Medical Record | ___ History & Physical | ___ Lab / Path Reports |
| ___ Discharge Summary | ___ Emergency Report | ___ Operative Reports |
| ___ Progress Notes | ___ Radiology Reports | ___ Immunizations |
| ___ EEG / ECG | ___ Other:_____ | |

**I request that copies of my health information indicated above be sent:**

From:_____
_____
_____
_____

To: *Medical Center West*
*Dr. Michelle Berry, D.O.*
*1201 S. Main Street, Ste. #110*
*Boerne ,TX 78006*

*I authorize the release of health information contained in my medical records including: Information regarding communicable disease and infection, as defined by statue of Texas Department of Public Health rules, which include Venereal Disease, Tuberculosis, Hepatitis A, B, C, Human Immunodeficiency Virus (HIV) and HIV Testing.*

- *Acquired Immunodeficiency Syndrome (AIDS) and AIDS related Complex (ARC).*
- *Alcohol and Drug Abuse treatment information*
- *Mental Health treatment records, Psychological and Social Service Information.*

## PURPOSE OF DISCLOSURE

__ Continued Care __ Attorney / Legal __ Insurance __ Personal Use
Other:_____

It is further understood the information released is for the specific purpose stated above and may not be provided in the whole or part to any other agency, organization or person. I further understand that correspondences / records from healthcare providers other than Medical Center West will not be released unless specifically requested above. This request may be revoked at any time, in writing, except for any action that has already been taken.

_____ _____
Signature of Patient / Legal Representative Date (Relation to patient)

Name: _____ Chart #: _____

DOB: _____ Date: _____

## *Financial Policy*

We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our current payment policy.

**ALL PAYMENTS ARE REQUIRED AT THE TIME OF SERVICE:** It is the patient's responsibility to provide Medical Center West with their correct insurance information. If for any reason it can not be provided, we will require you to pay the cash price of any services provided and a receipt will be provided to you so that you may submit a claim on your own.Payment is required at the time services are rendered unless prior arrangements have been made. This includes applicable coinsurance, deductible, and co-payments for participating insurance companies. Dr. Berry accepts cash, personal check, Via, Mastercard, Discover, and American Express.

**There is a $35.00 service charge for returned checks.**

Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling appointments. We understand that people have financial difficulty, but we are not able to finance your healthcare.

**INSURANCE:*Under the clean claims rules the HMO or insurance company has 45 days to pay or deny a clean claim.***We bill your insurance company as a courtesy to you. You are expected to pay your deductible, copays and coinsurance at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. All insurances are verified 24 hours prior to appointments. If benefits cannot be confirmed, you will be required to pay the cash price of all services. We do not bill secondary insurance companies. We will provide you with a receipt at the time of service that will include all information necessary for submitting claims to your insurance company.

**REFUNDS:** Overpayments will be refunded upon written request to the responsible party within 30 days.

**MISSED APPOINTMENTS/LATE/CANCELLATIONS:** Broken appointments represent a cost to us, to you and to other patients who could have been seen in that time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-canceled appointments. Excessive abuse of scheduled appointments will result in discharge from our office. **I have read and understand Dr. Berry's Financial Policy. I agree to assign insurance benefits to Decision Height, Inc. dba Medical Center West and Dr. Michelle Berry, D.O.I further agree that I am responsible for all charges incurred and will pay my balance in full should my insurance company not pay my account in 45 days from the date of service.**

Signature of Insured or Authorized Representative: _____

Date: _____

# Medical Information Release Form

## HIPAA Release Form

Name: _____ Date of Birth: ____/____/____

We are unable to discuss your treatment with anyone unless you give us written permission.

[ ] I authorize the release of information including the diagnosis, records, images, examination rendered to me, and claims information. This information may be released to:

Please note: Certain treatments may require the patient be sedated. You will need to have a driver for such treatment. Your driver must be listed on this medical information release form prior to treatment.

[ ] My general and/or referring dentist Names: _____

[ ] Spouse Name: _____

[ ] Child(ren) Name(s): _____

[ ] Parent Name: _____

[ ] Other Name: _____

[ ] Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

## Messages

Please call my [ ] home [ ] work [ ] cell Number _____

If unable to reach me:

[ ] You may leave a detailed message

[ ] Please leave a message asking me to return your call

[ ] Other _____

The best time to reach me is (day) _____ between (time) _____.

If unable to reach me:

[ ] You may leave a detailed message

[ ] Please leave a message asking me to return your call

[ ] Other _____

The best time to reach me is (day) _____ between (time) _____.

I have received a copy of this office's Notice of Privacy Practices.

Signed: _____ Date: ____/____/____

# PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
*(use "✓" to indicate your answer)*

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |
| add columns | | + | + | |
| TOTAL: | | | | |

*(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).*

| | |
|---|---|
| 10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people? | Not difficult at all _____<br>Somewhat difficult _____<br>Very difficult _____<br>Extremely difficult _____ |