Board Certified Internal Medicine **Dr. Mark Lindemann, D. O.**

4545 Bellaire Drive S. Ste 9 Fort Worth, Texas 76109 Phone: 817-763-8300 Fax: 817-377-9486

Patient Information Form

Patient's Full Name:			**Phone#:**	**Cell#:**
Address:		City:	St:	Zip:
Sex: F M	Marital Status:	Date of Birth:	Social Security#:	DL#:
Patient email address:		Race:	Ethnicity:	
Referring Physician (Doctor's first& last name)				
Pharmacy name, address and phone number:				
Patient's Employer:				
Employer's Addresss:				
Spouse's/Guardian's Name:	Phone#:	Date of Birth:	Social Security#:	
Employer:		Address:		
***Is this a work-related injury?** **Employer at time of injury with contact info:**		**If yes, date of injury?**		
In case of Emergency contact:		Relationship:	Phone#:	
PRIMARY INSURANCE COVERAGE				
Insurance Company:				
Name of Insured:		Insured's DOB:		
Relationship of Insured:		Insured's SS#:		
Insured's Employer:				
Insurance Claims Address:		Insurance Phone#:		
City:	State:	Zip:		
Policy#:	Group#			
SECONDARY INSURANCE COVERAGE				
Insurance Company:				
Name of Insured:		Insured's DOB:		
Relationship of Insured:		Insured's SS#:		
Insured's Employer:				
Insurance Claims Address:		Insurance Phone#:		
City:	State:	Zip:		
Policy#:	Group#:			

INSURANCE AUTHRIZATION AND ASSIGNMENT: I understand that I am responsible for all charges incurred by me and all charges not allowed by my insurance company. I authorize release of medical information necessary to process my claims. I authorize payment of any assigned medical benefits to the office located at 4545 Bellaire Drive S Ste.9, Fort Worth, Tx 76109.

Signature: _____ Date: _____

Dr. Mark Lindemann, D.O.

Board Certified Internal Medicine

NEW ADULT PATIENT

Name:_____

Date of Birth:_____

Today's Date:_____

Please tell us the **REASON FOR TODAY'S VISIT** or any special concerns you would like to discuss with your doctor today:_____

_____

Please list your **CURRENT MEDICATIONS:**

NAME OF MEDICATION	DOSAGE (ie, milligrams)	HOW TAKEN (ie, tablet/s daily)

Please list any **ALLERGIES** to medications/foods:

ALLERGY	TYPE OF REACTION (ie, rash, nausea)

Please provide your **IMMUNIZATION HISTORY:**

	YES	NO	DATE		YES	NO	DATE
Tetanus-Diptheria Booster				Hepatitis A Vaccine			
Influenza Vaccine (Flu Shot)				Hepatitis B Vaccine			
Pneumococcal Vaccine				Human Papilloma (HPV)			
Tuberculosis (TB) Skin Test				Varicella Vaccine			

NAME:_____DOB:_____

Please provide your **PAST MEDICAL HISTORY:**

Check all that apply:

	Allergies		Blood Clots		Gallbladder disease		MI (heart attack)
	Anemia		Cancer, Type:		GERD (reflux)		Osteoarthritis
	Angina (chest pain)		CVA (stroke)		Hepatitis C		Osteoporosis
	Anxiety		COPD (emphysema)		High Cholesterol		Peptic ulcer disease
	Arthritis		CAD (heart disease)		High Blood Pressure		Renal disease (kidneys)
	Asthma		Crohn's disease		Irritable Bowel disease		Seizure Disorder
	Atrial Fibrillation		Depression		Liver disease		Thyroid disease
	BPH (enlarged prostate)		Diabetes		Migraine headaches		

Please tell us about any **SURGERIES** you have had by checking all that apply, you may indicate the **date/year if known:**

	Angioplasty		Colon removed		Small Bowel resection		**GENDER SPECIFIC FEMALE**
	Angioplasty with stent		Colostomy		Thyroidectomy		Breast Augmentation
	Appendix		Gastric Bypass		Tonsillectomy		Bilateral Tubal ligation
	Arthroscopy knee		Hernia repair		Colonoscopy		Breast biopsy
	Back surgery		Hip replacement				Cesarean section
	CABG (open heart surgery)		Knee replacement		**GENDER SPECIFIC MALE**		D & C
	Carpal tunnel release		Liver Biopsy		Prostatectomy		Hysterectomy
	Cataract		Pace maker		Vasectomy		Mastectomy
	Gallbladder removal		ORIF (repair broken bone)				Breast Reduction

Please list any **ADDITIONAL PAST MEDICAL OR PAST SURGERY HISTORY:** _____

_____

FAMILY HISTORY:	Age if living	Age at death	Health problems or cause of death
Mother			
Father			
Brothers			
Sisters			
Children:			

NAME: _____ DOB: _____

Review of systems:

Please check whether you currently have or have had these conditions in the last few weeks:

	YES	NO
Fatigue		
Fever or chills		
Recent weight gain		
Headache		
Vision problems		
Double vision		
Blurred vision		
Eye itching		
Eye pain		
Hearing loss		
Earache		
Ringing in the ears		
Runny Nose		
Nose bleeds		
Nasal congestion		
Snoring		
Hoarseness		
Sore throat		
Mouth sores		
Breast lump or pain		
Chest pain		
Irregular heart beat		
Pounding heart beat		
Shortness of breath		
Cough		
Wheezing		
Decreased appetite		
Increased appetite		
Difficulty swallowing		
Heartburn		
Nausea		
Vomiting		
Abdominal pain		

	Yes	No
Black tarry stools		
Rectal bleeding		
Diarrhea		
Constipation		
Blood in urine		
Urinating too often		
Too much urine		
Getting up at night to urinate		
Pain with urination		
Excessive thirts		
Weakness		
Easy bruising		
Muscle aches		
Joint pain		
Joint stiffness		
Swelling in arms or legs		
Dizziness		
Fainting		
Memory problems		
Numbness		
Anxiety		
Depression		
Trouble sleeping		
Hallucinations		
Dry skin		
Itching		
Lump or spot on skin		
Rash		
Stress		

NAME: _____ DOB: _____

FOR MALES ONLY:

	YES	NO
Straining with urination		
Pain or lump on testicle		
Discharge from penis		
Prostate problems		
Difficulty with erection		
Sexual difficulties		

FOR FEMALES ONLY:

Date of last menstrual period:		
Date of last mammogram:		
Number of pregnancies:		
Number of live children:		
	YES	NO
Any history of abnormal pap smears? If yes, when:		
Are periods regular:		
Pelvic pain:		
Abnormal vaginal bleeding:		
Vaginal discharge:		
Sexual difficulties:		

Please provide your **SOCIAL HISTORY:**

Do you smoke? Yes No Never Former Type of tobacco: _____

Packs Per Day: _____ Years smoked: _____ Year Quit: _____

Do you drink alcohol? Yes No Never Former Type of Alcohol: _____ Drinks per week: _____

Have you ever had a drinking problem? Yes No

Do you use Marijuana, Cocaine, any street drugs/prescription drugs not prescribed for you?

Yes ____ No____ (leave blank if you would like to discuss with the doctor)

Who lives in your home? (spouse, children, in-laws, significant other, etc.)

_____

What is your occupation? _____ What are your hobbies? _____

Do you get regular exercise? Describe) _____

Education: _____

Have you recently traveled outside of the state of Texas or traveled outside of the country? (If so, when and where?)

_____

NAME:_____ DOB:_____

Geriatric Intake ----- Please complete if you are over the age of 65 years old, or if you have concerns about the topics listed below.

Do you have medical Durable Power of Attorney for healthcare? No____ Yes ____ (If yes, bring a copy)

Name and relationship: _____

We want to know if **you need** help with any of the following and **who helps you**.

Task	Don't need help	Need help	Who helps
Feeding yourself			
Getting from bed to chair			
Getting to the toilet			
Getting dressed			
Bathing			
Using the telephone			
Taking your medicines			
Preparing your meals			
Managing money/finances			
Doing laundry			
Doing housework			
Shopping for groceries			
Driving			
Doing handyman work			
Climbing a flight of stairs			

Are you afraid of falling? Yes No

Have you had a fall in the past year? Yes No

If yes, please tell us about your fall; date and how it happened:

_____

_____

Did you see a doctor or other professional for treatment after the fall? Yes No

Do you use a walking aid such as a cane or walker? Yes No

Do you drive? Yes No

Mark A Lindemann DO PA

4545 Bellaire Dr. South Suite 9

Fort Worth, TX 761091811

*Phone: (817)763-8300 **Fax: (817)377-9486*

LATE POLICY

To maintain an efficient schedule, if you are more than 15 minutes late for your appointment, you may be asked to reschedule for a later date. If you think that you will be late for your appointment, please call us as soon as possible, so that we may advise you if your late arrival can be accommodated, or if we will need to reschedule you.

No Show Policy

If you do not come to your appointment and/or you do not call to notify us of cancellation at least 1 HOUR prior to your appointment, you will be considered a no-show. If you have three no-shows, you may be discharged from our clinic.

A no show will result in a **$35.00** charge; this charge must be paid prior to your next appointment.

_____ _____

Signature **Date**

Medical Release of Information Form

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Previous Name: _____

Home Phone: _____ Other Phone: _____

Address, City, State, Zip _____

I request and authorize _____
(Name of Physician and Clinic/Practice you want to release your records)

To release the medical record of the above named patient to ***(the place you want your medical records to be sent)*****:**

Name of recipient: Dr. Mark Lindemann

Address: 4545 Bellaire Dr. S. Suite 9
Fort Worth, Tx 76109

City & State: _____ Zip Code: _____

Phone: 817.763.8300 Fax: 817.377.9486

Reason for release (required field): _____

Health Care information relating to the following treatment condition or dates of treatment:

_____

This information may contain x-ray reports, laboratory reports, EKG reports, other diagnostic reports, consults, etc.

This request and authorization applies to: (initial appropriate line)

____All Health Care information **including** information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use. (Please circle all that apply)

____All Health Care Information **excluding** information relating to HIV/Aids testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use. (Please circle all that apply)

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.
Treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes.
I understand I have the right to revoke this authorization by providing a written request to the above name physician or organization. I understand that the revocation will not apply to information that has already been released in good faith. I understand that the condition for release is not based on payment for treatment and care, enrollment or eligibility on whether I sign the authorization.

_____ _____
Signature of patient or authorized representative Date

_____
Relationship or status if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

Unless otherwise revoked this Authorization will expire six months from the date signed or the following designated event: _____
I understand that authorizing the disclosure of this health information is voluntary.

DR. MARK LINDEMANN
DO PA AND ASSOCIATES
INTERNAL MEDICINE

Patient Authorization for Practice to Release Protected Health Information

Our Notice of Privacy provides information about how we may use and disclose protected health information (PHI) about you. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations, or for other purposes permitted by law. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA).

- Leave a message on your answering machine regarding appointments? **YES or NO**
- Leave a message on your answering machine regarding lab and pathology results or any other health care issues? **YES or NO**
- Contact you at your place of employment regarding appointments, labs and pathology results or any other health care issues? **YES or NO**
- Discuss your medical condition with any member of your household? Please list below **YES or NO**

_____

_____

_____

_____

Expiration date of this authorization: ONE YEAR FROM DATE OF SIGNATURE

The above mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

To the extent that this form authorizes the sale of your Protected Health Information, such a disclosure will result in remuneration to the Practice.

By signing this form, you authorize the Practice to use and disclose Protected Health Information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice

This authorization was signed by: _____
Sign Name – Patient or Representative

Print name _____
Print Name – Patient or Representative

Relationship to Patient (if other than patient): _____

Date: _____