New Patient Survey

Family Medical Home
Dr. Robert L. Hogue, MD, P.A.
101-A South Park Drive
Brownwood, Texas 76801

Please complete the following questionnaire:

NAME: _____ DATE: _____

How Did You Hear About Dr. Robert L. Hogue's Office?

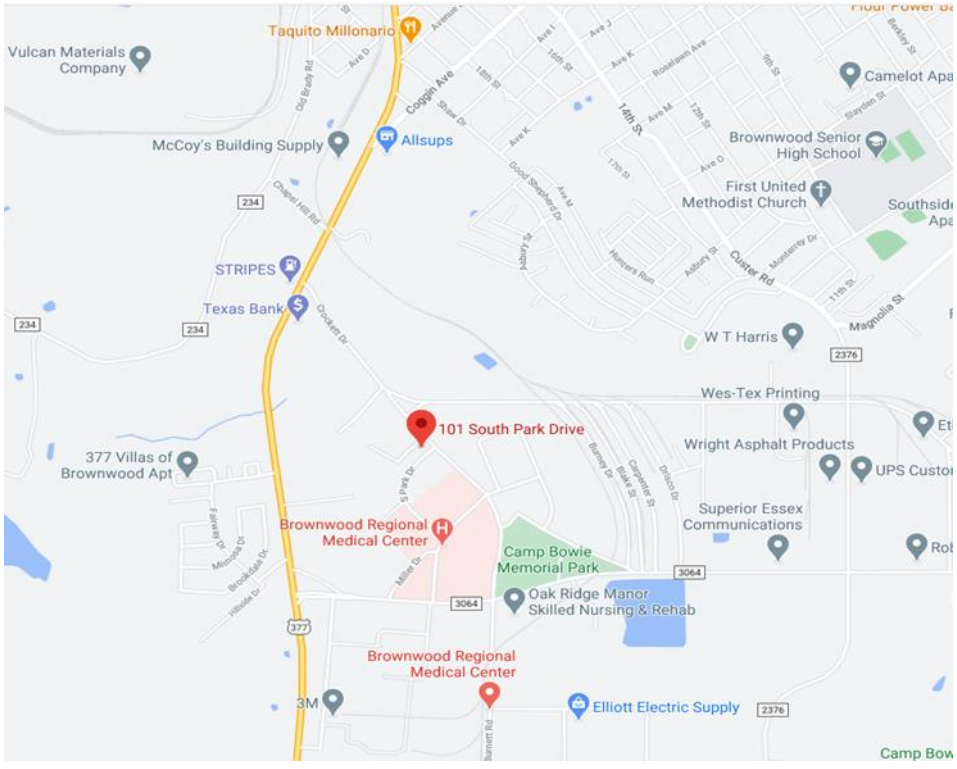
Family Member?___ Insurance?___ Friend?___

Phone Book? Frontier ___ or Area Wide ___
Which Ad? ___Family Medicine ___OB ___Dermatology ___Surgery

Internet? Google ___ Facebook____ Instagram____

Other Source? *(other doctor, HPU, etc)*_____

Please bring your current insurance card with updated PCP as Dr. Hogue, if required, valid picture ID (18 and older) and medications in the original pill bottle to your appointment.



Robert L. Hogue M.D., P.A.
Family Medicine

Health Information

Please complete in detail. State if NONE or UNKNOWN

Adult

Name:_____ Age:_____ Date:_____

Sex:_____ Occupation:_____ Referred by:_____

General Health-(Circle one) Excellent Good Fair Poor

Allergies to Medications: (With rash, itching):_____

Other problems with Medications (Nausea, etc.):_____

Operations-Include C-Sections, tonsils, appendix, etc. with age and reason of surgery:_____

_____

Hospitalizations-Other than surgery and normal deliveries: _____

_____

Did you have any serious illnesses in childhood, or complications of childhood diseases? (Circle One)
Yes No Don't know Explain:_____

Have YOU or anyone in your FAMILY (mother, father, brothers, sisters, grandparents, aunts or uncles ever had:

	SELF	NONE	FAMILY MEMBERS-who and which side of the family
Cancer	____	_____	_____
Diabetes	____	_____	_____
High Blood Pressure	____	_____	_____
Stroke	____	_____	_____
Epilepsy	____	_____	_____
Tuberculosis	____	_____	_____
Heart Disease	____	_____	_____
Kidney Disease	____	_____	_____
Rheumatic Fever	____	_____	_____
Nervous Breakdown	____	_____	_____
Blood Disease Or Blood Disorders	____	_____	_____

Date of last tetanus: _____
Do you smoke? _____How long have you smoked? _____How much? _____ Do you drink alcohol? _____
How much? _____ Do you drink coffee?_____How much? _____
List any medications you take regularly or have recently taken (with dose) _____
_____

Pharmacy Name:_____ Pharmacy Address:_____

WOMEN: Date of last menstrual period_____ Are you now pregnant? _____
Do you menstruate regularly? _____Number days of flow _____How often? _____
Excessive cramps? _____Excessive flow? _____Times pregnant _____Number of babies you have had_____
Date of last Pap smear_____

Please list any serious illnesses or past health problems or injuries not covered above: _____
_____

Family Medical Home
Robert L. Hogue M.D.

PATIENT INFORMATION **Religion**_____ **Today's Date**_____

Name: _____ D.O.B._____/_____/_____ Current age: ____
Last First MI Nickname

Sex: Male__Female___Marital Status: S M D W Social Security #: _____-_____-_____Spouse:_____

Address: _____ Relationship to Responsible Party: _____

City: _____ State: _____Zip: _____

Home Phone#: {_____}_____ Cell Phone#: {_____}_____

Email Address: _____

Employer: _____ Employer Work #: {____}_____

Referring Physician: _____ Referring Physician Phone: {_____}_____

RESPONSIBLE PARTY INFORMATION

Name: _____ Home Phone #: {____} _____
Last First MI
Address: _____ City: _____

State: _____ Zip: _____ DOB: _____/_____/_____ Current Age:_____

Social Security #: _____-_____-_____ Male: _____ Female: _____ Marital Status: S M D W

Employer: _____ Employer Phone #: {____}_____

Address: _____ City: _____State: _____ Zip: _____

IN CASE OF EMERGENCY-*NEXT OF KIN NOT LIVING AT SAME ADDRESS*

Name: _____Relationship: _____Phone#: {___}_____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION:

Primary Insurance
Ins: Name: _____

Address: _____

Phone #: {____}_____

Group #: _____

Insured ID #: _____

Secondary Insurance
Ins. Name: _____

Address: _____

Phone #: {____}_____

Group #: _____

Insured ID #: _____

Signature: _____

I authorize benefits to be paid to Robert L. Hogue M.D. and the release of medical information for the purpose of processing insurance claims.

PLEASE FURNISH YOUR INSURANCE CARD(S) FOR COPYING

L1

Authorization Form for Release of Protected Health Information

Date: _____

____ I **DO NOT** authorize *Robert L. Hogue M. D.* to release any or all of my protected health information to any individual.

____ I **authorize** *Robert L. Hogue, M.D.* to use and disclose my protected health information regarding my medical care to the following individuals.

Name:_____ Relationship to patient:_____

Name:_____ Relationship to patient:_____

Name:_____ Relationship to patient:_____

This Authorization is in effect until: Further Notice_____ Other:_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the following person at the office of Robert L. Hogue, M.D.:

Traci Lasyone
101 A South Park Dr.
Brownwood, TX 76801

I understand that the information released by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA privacy regulations.

_____ _____
Name **DOB**

_____ _____
Signature of Patient or Guardian **Relationship to Patient**

_____
Witness

Notice of Privacy Practices
Acknowledgement Review

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Patient Name **Date of Birth**

Signature of Patient or Guardian **Date**

Relationship to Patient

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Robert L. Hogue, M.D., P.A.
Family Medicine

CONSENT TO TREATMENT

DATE: _____ TIME: _____

1. I, _____ (name of person giving consent), (the _____ (Relationship, if other than patient) of _____ (Patient name)), hereby voluntarily consent to outpatient care at Robert L. Hogue, M.D., P.A. Family Practice Office encompassing routine diagnostic procedures, examination and medical treatment including (but not limited to) routine laboratory work (such as blood, urine and other studies), taking X-rays, heart tracings, and administration of medications prescribed by the physician.

2. I further consent to the performance of those diagnostic procedures, examinations, and rendering of medical treatment by the doctor, his assistants or his designees as is necessary in the doctor's judgment. I understand that I (he/she) will be a part of the teaching program of Robert L. Hogue, M.D., P.A. Family Practice, when doctors-in-training are under Dr. Hogue's direction.

3. I consent to the use of photography for the purpose of documentation of my medical conditions. I further consent for these photographs to be shared with other health professionals as indicated for my medical care

4. I understand that Dr. Hogue utilizes the services of a physician assistant. I understand that he/she is not a doctor but qualified to perform many of the services provided in this practice. I understand that I may specifically request to be seen by Dr. Hogue at any time.

5. RELEASE OF INFORMATION: (A) I authorize Robert L. Hogue M.D.,P.A. to release medical information to third party insurance carriers for the purpose of filing insurance claims related to my (his/her) medical care. (B) I further authorize the release of medical information about treatment here to my (his/her) doctor or any doctor designated by me.

6. I understand that this consent form will be valid and remain in effect as long as I (he/She) attend the Family Practice Clinic of Robert L. Hogue M.D., P.A.

7. I have read this form and understand it contents.
   COMMENTS: _____

   If patient is a minor or is unable to consent, complete the following:

   A. Patient is a minor, _____ years of age.

   Name of Father: _____ Name of Mother: _____

   B. Patient is unable to consent because: _____

Signature of Patient or Person Authorized to consent for patient	**Relationship to patient**	**Witness**

Robert L. Hogue, M.D., P.A.
Family Medicine

Statement of Understanding

ALL PROFESSIONAL FEES ARE DUE AT THE TIME OF SERVICE, UNLESS PREVIOUS ARANGEMENTS HAVE BEEN MADE.

Financial Agreement

1. Services are rendered to the patient, not the insurance company. As a *courtesy*, our office will file your insurance if proper information is received.

    - *You are responsible* for co-pays, co-insurance, deductibles, non-covered services, and items considered "not medically necessary" by your insurance company.
    - For unpaid claims over 45 days, it is *your responsibility* to follow up with your insurance and the balance due is considered due and payable.

2. It is *your responsibility* to notify our front desk staff of any insurance or address changes

3. *You will be responsible* for any charges that occur if we are not notified.

4. Any debt incurred to collect a debt will be at the expense of the patient/responsible party.

PATIENT AUTHORIZATION

I authorize **Dr. Hogue** to submit insurance claims using my signature on file below.
I authorize the release of any medical information necessary in order to process this assignment on the claim.
I authorize payment of medical benefits to be paid directly to **Dr. Hogue** for services described on the claim form.

_____ _____

Patient Signature (or authorized representative) ***Date***