Noe R. Olvera, M.D., P.A.
2705 Hospital Dr. Suite 210
Victoria, Texas 77901

PATIENT REGISTRATION FORM

PATIENT INFORMATION

PATIENT NAME _____ AGE _____ SEX ☐ M ☐ F
LAST FIRST MI

SOCIAL SECURITY NUMBER _____ DOB _____ MARITAL STATUS ☐ M ☐ S ☐ D ☐ W

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE NUMBER _____ CELL. PHONE NUMBER _____

MAILING ADDRESS (IF DIFFERENT FROM ABOVE) _____ PHONE NUMBER _____ REFERRED BY _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____ BUSINESS PHONE _____

NAME _____ RELATIONSHIP _____ PHONE NUMBER _____

PLEASE GIVE EMERGENCY IFNORMATION FOR A PERSON WHO DOES NOT LIVE WITH YOU

PERSON RESPONSIBLE FOR ACCOUNT (IF PATIENT IS A MINOR)

NAME OF RESPONSIBLE PARTY _____
LAST FIRST MI

ARE YOU THE LEGAL GUARDIAN? ☐Y ☐N SOCIAL SECURITY NUMBER _____

ADDRESS (IF DIFFERENT FROM PATIENT) _____ CITY _____ STATE _____ ZIP _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____ BUSINESS PHONE _____

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY _____

MAILING ADDRESS FOR CLAIMS _____ CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____ POLICY HOLDER _____

ID# _____ GROUP # _____ MEMBER # _____

SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY _____

MAILING ADDRESS FOR CLAIMS _____ CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____ POLICY HOLDER _____

ID# _____ GROUP # _____ MEMBER # _____

PERMISSION TO TREAT PATIENT

I HEREBY AUTHORIZE MEDICAL CARE BY Noe R. Olvera, M.D., P.A. FOR THE PERSON NAMED ABOVE AS "PATIENT" ON THIS DOCUMENT. I ALSO GIVE Noe R. Olvera, M.D., P.A. PERMISSION TO FILE ON MY INSURANCE FOR MY MEDICAL CARE AND/OR PROCEDURES. I ALSO UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE FOR SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

PATIENT SIGNATURE: _____

GUARDIAN SIGNATURE (If patient is a minor): _____

ASSIGNMENT OF INSURANCE BENEFITS

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO Noe R. Olvera, M.D., P.A. OF ALL INSURANCE BENEFITS RELATED TO MY CARE. I AUTHORIZE Noe R. Olvera, M.D., P.A. TO RELEASE ANY INFORMATION REQUIRED TO SECURE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS. I ALSO UNDERSTAND THAT I MAY BE RESPONSIBLE FOR ANY CO-PAYMENT DUE AT TIME OF ANY AND ALL OFFICE VISIT(S).

PATIENT SIGNATURE: _____

GUARDIAN SIGNATURE (If patient is a minor): _____

MEDICARE AUTHORIZATION

I REQUEST THAT PAYMENT OF MY MEDICARE BENEFITS BE MADE TO Noe R. Olvera, M.D., P.A. ON MY BEHALF FOR ANY SERVICES FURNISHED BY Noe R. Olvera, M.D., P.A. OR UNDER their DIRECTION. I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IN MEDICARE ASSIGNED CASES, THE PHYSICIAN AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE AND THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, CO-INSURANCE, AND NON-COVERED SERVICES. CO-INSURANCE AND THE DEDUCTIBLE ARE BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE CARRIER.

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PATIENT HISTORY FORM

Name _____ Birthdate:_____/_____/_____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Referred here by: (Check one) ☐ Self ☐ Family ☐ Friend ☐ Doctor ☐ Other Health Professional

Name of person making referral: _____

The name of the physician providing your primary medical care:_____

Briefly describe your present symptoms: _____

_____

_____

_____

_____

Date symptoms began (approximate): _____

Previous treatment for this problem (include physical therapy, surgery, and injections; medications to be listed later)

_____

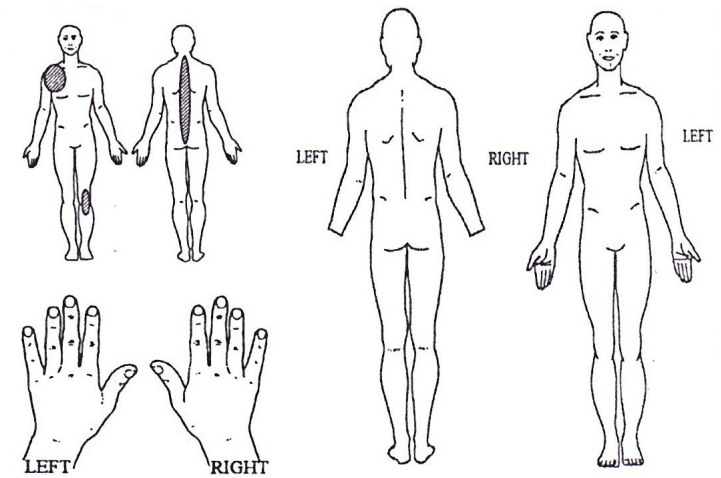
_____

_____

_____

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.

Example:



Please list the names of other practitioners you have seen for this problem:

_____

_____

_____

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you had any of the following? (Check if "yes")

☐ Arthritis (unknown type)	☐ Psoriasis	☐ Rheumatoid Arthritis	☐ Crohn's
☐ Osteoarthritis	☐ Lupus or "SLE"	☐ Osteoporosis	☐ Psoriatic Arthritis
☐ Gout	☐ Colitis	☐ Ankylosing Spondylitis	☐ Sjogrens

Other Arthritis conditions: _____

_____

SYSTEMS REVIEW

As you review the following list, please check any of those problems, which have significantly affected you.

Constitutional

- ○ Recent weight gain Amount _____
- ○ Recent weight loss Amount _____
- ○ Fatigue
- ○ Weakness
- ○ Fever

Eyes

- ○ Uveitis
- ○ Episcleritis
- ○ Iritis
- ○ Dryness

Ear-Nose-Mouth-Throat

- ○ Nosebleeds (frequent)
- ○ Dryness in nose
- ○ Sores in mouth
- ○ Dryness of mouth
- ○ Difficulty in swallowing
- ○ Snoring

Respiratory

- ○ Shortness of breath
- ○ Cough
- ○ Coughing of blood
- ○ Wheezing (asthma)

Gastrointestinal

- ○ Nausea
- ○ Constipation
- ○ Persistent diarrhea
- ○ Blood in stools
- ○ Black stools
- ○ Heartburn

Neurological System

- ○ Headaches
- ○ Dizziness
- ○ Numbness/tingling

Endocrine

- ○ Excessive thirst

Genitourinary

- ○ Protein in urine
- ○ Pain or burning on urination
- ○ Blood in urine
- ○ Vaginal dryness
- ○ Vaginal ulcers

For Women Only:

Number of pregnancies _____

Number of miscarriages _____

Integumentary
(Skin/and or breast)

- ○ Easy bruising
- ○ Rash
- ○ Hives
- ○ Sun sensitive (sun allergy)
- ○ Tightness
- ○ Nodules/bumps
- ○ Hair loss
- ○ Color changes of hands or feet in the cold

Psychiatric

- ○ Excessive worries
- ○ Anxiety
- ○ Easily losing temper
- ○ Depression
- ○ Agitation
- ○ Difficulty falling asleep
- ○ Difficulty staying asleep

Hematologic/Lymphatic

- ○ Swollen glands
- ○ Anemia
- ○ Cancer
- ○ Low platelets
- ○ Low white blood cells

Allergic/Immunologic

- ○ Seasonal allergies
- ○ Allergies to medicine

SOCIAL HISTORY

Do you smoke? ☐ No ☐ Yes ☐ Past – How long ago? _____

Do you drink alcohol? ☐ No ☐ Yes - Number per week _____

Have you used drugs for reasons that are not medical? ☐ No ☐ Yes

If yes, please list: _____

Do you exercise regularly? ☐ No ☐ Yes Type_____ Amount per week_____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? ☐ No ☐ Yes Do you wake up feeling rested? ☐ No ☐ Yes Do you snore? ☐ No ☐ Yes

PAST MEDICAL HISTORY

List past medical problems

_____

_____

_____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

Previous Operations

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		

Any previous fractures? ☐ No ☐ Yes Describe:_____

FAMILY HISTORY

Do you know of any blood relative who has or had: (check and give relationship)

☐ RA ☐ Ankylosing Spondylitis ☐ Ulcerative Colitis ☐ Psoriasis ☐ Gout

☐ Lupus or "SLE" ☐ Crohn's ☐ Psoriatic Arthritis ☐ Sjogrens

MEDICATIONS

Drug allergies: ☐ No ☐ Yes To what? _____

Type of reaction: _____

PRESENT MEDICATIONS List any medications you are taking. Include such items as aspirin, vitamins, calcium and other supplements, etc.

Name of Drug	Dose (include strength & number of pills per day)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

PAST MEDICATIONS Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, how long you were taking the medication, and any reactions you may have had. Record your comments in the spaces provided.

Drug Names/Dosage	Length of Time	Reactions
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		
Circle any you have taken in the past		
Ansaid (flurbiprofen) Arthrotec (diclofenac + misoprostil) Celebrex (celecoxib) Vioxx (rofecoxib) Clinoril (sulindac) Daypro (oxaprozin)		
Aspirin (including coated aspirin) Disalcid (salsalate) Dolobid (diflunisal) Feldene (piroxicam) Lodine (etodolac) Indocin (indomethacin)		
Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen) Meloxicam (mobic) Voltaren (diclofenac)		

Drug Names/Dosage	Length of Time	Reactions
Pain Relievers		
Acetaminophen (Tylenol)		
Codeine (Vicodin, Tylenol 3)		
Propoxyphene (Darvon/Darvocet)		
Other:		
Other:		
Disease Modifying Antirheumatic Drugs (DMARDS)		
Gold		
Hydroxychloroquine (Plaquenil)		
Methotrexate (Rheumatrex)		
Azathioprine (Imuran)		
Sulfasalazine (Azulfidine)		
Cyclophosphamide (Cytoxan)		
Cyclosporine A (Sandimmune or Neoral)		
Etanercept (Enbrel)		
Infliximab (Remicade)		
Rituximab		
Humira		
Orencia		
Osteoporosis Medications		
Estrogen (Premarin, etc.)		
Alendronate (Fosamax)		
Etidronate (Didronel)		
Raloxifene (Evista)		
Calcitonin injection or nasal (Miacalcin, Calcimar)		
Risedronate (Actonel)		
Boniva		
Reclast		
Gout Medications		
Probenecid (Benemid)		
Colchicine		
Allopurinol (Zyloprim/Lopurin)		
Uloric		
Other:		
Others		
Cortisone/Prednisone		
Hyalgan/Synvisc injections		
Glucosamin		
Please list supplements:		

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that nay part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against your for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature: _____ Date: _____

Noe R. Olvera, M.D., P.A.
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CONSENT FOR RELEASE OF INFORMATION

I understand and consent that my medical information may be released to the following family or friends:

NAME	RELATIONSHIP	TELEPHONE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I give my permission for reminders and messages to be left on my answering machine or with someone at my home telephone number.

_____ YES _____ NO

_____
Signature of Patient or Representative

_____
Patient Name (Please Print)

_____
Date