Abilene Diagnostic CLINIC

B. Cory Brown, DPM
1665 Antilley Rd Suite 210
Abilene, Tx 79606
Phone: 325-437-8641
Fax: 325-793-5107

Date: _____

Patient Information:

Last Name: _____ First Name: _____ M.I.: _____
Address: _____ City: _____ State: _____ Zip: _____
DOB: _____ Social Security #: _____ Sex: ___ Marital Status: M S W D
Primary Phone #: _____ (Please check one) Cell __ Home__ Work__
Secondary Phone #: _____ (Please check one) Cell __ Home__ Work__
Employer Name: _____ Occupation: _____

Responsible Party: (If different from above or patient is a minor)
Last Name: _____ First Name: _____ M.I.: _____
Address: _____ City: _____ State: _____ Zip: _____
DOB: _____ Social Security #: _____ Sex: ___ Marital Status: M S W D
Primary Phone #: _____ (Please check one) Cell __ Home__ Work__
Secondary Phone #: _____ (Please check one) Cell __ Home__ Work__
Employer Name: _____ Occupation: _____

Emergency Contact:
Last Name: _____ First Name: _____ M.I.: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone #: _____

Primary Care Physician: _____ **Last Date Seen by PCP:** _____

Local Pharmacy w/Address: _____

Mail Order Pharmacy: _____

Race (Please Circle One)

American Indian or Alaskan Native Asian Black or African American More than One Race White

Native Hawaiian Other Pacific Islander Refused to Report/Unreported

Ethnicity (Please Circle One)

Hispanic or Latino Not Hispanic or Latino Refused to Report/Unreported

Language _____

INSURANCE INFORMATION:

Primary Ins/ID: _____

Are you (the patient) the policyholder? Yes No (please circle one)

If No, please give the policyholder's information below:

Name & DOB: _____ SSN#: _____

Address if different from patient's: _____

Secondary Ins/ID: _____

Are you (the patient) the policyholder? Yes No (please circle one)

If No, please give the policyholder's information below:

Name & DOB: _____ SSN: _____

SSN#: _____

Address (if different from patient's: _____

I, the undersigned authorize payment of medical benefits to Abilene Diagnostic Clinic, PLLC for any services furnished to me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice & treatment of supplies provided to me. This information will be used to the purpose of evaluating and administering claim of benefits.

Signature:_____ DOB:_____ Date:_____

Parent or Guardian (if child is under 18) Relationship to patient: _____

General Consent for Treatment

I, knowing that I am suffering from a condition requiring diagnostic, medical, or surgical treatment, do hereby voluntarily consent to such procedures and care and to such medical, surgical or other services under the general and specific instructions of B. Cory Brown,DPM, his/her assistants, or designee as is necessary in his/her judgement. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to result of treatment or examination by B. Cory Brown, DPM, his/her assistants or designee.

Patient Signature:_____ Date:_____

Notice of Privacy Practices

I acknowledge that Abilene Diagnostic Clinic, PLLC provided me the opportunity to review the Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Patient Signature:_____ Date: _____

Personal Representative:_____ Date:_____
(if applicable)

Email Request

If you would like to be able to access your medical information online, please provide your e-mail address below, you will receive an invite to the program via e-mail.

Email address: _____

Patient signature: _____ Date: _____

Abilene
DIAGNOSTIC CLINIC

PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding patient for whom authorization is made:

Full Patient Name: _____

Other Name(s) Used: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: ( ) _____ Email *(Optional)*: _____

ADC health care provider or health care entity authorized to disclose this information:

Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: ( ) _____ Fax: ( ) _____

Disclose information to (who can receive and use this information outside of ADC):

Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: ( ) _____ Fax: ( ) _____

Specific information to be disclosed:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (**except psychotherapy notes**), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.

☐ Other: _____

Include: (Indicate by initialing)

_____ Drug, Alcohol or Substance Abuse Records

_____ Mental Health Records (Except Psychotherapy Notes)

_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)

_____ Genetic Information (Including Genetic Test Results)

Reason for release of information:
(Choose all that Apply)

☐ Treatment/Continuing Medical Care
☐ Personal Use
☐ Billing or Claims
☐ Insurance
☐ Legal Purposes
☐ Disability Determination
☐ School
☐ Employment
☐ Other (*Specify*): _____

I do_____ I do not _____ authorize my (or patient's) protected health information to be disclosed electronically. If the request is for paper copy and more than 50 pages, the documents will be mailed and not faxed. Appropriate charges for electronic or paper copies will be applied.

The individual signing this form agrees and acknowledges as follows:

(i)**Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii)**Effective Time Period:** This authorization will be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month:_____ Day:_____ Year:_____.

(iii)**Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv)**Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL, and SUBSTANCE ABUSE; MENTAL HEALTH INFORMATION,** except psychotherapy notes; **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION; and GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v)**Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without any specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient/Legal Representative:_____ Date:_____

If Legal Representative, relation to Patient: _____

Witness (optional):_____ Date:_____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable):_____ Date:_____

Patient Name_____

Height_____ Primary Physician_____

Reason for visit:

Please provide a list of any medications with dosage and frequency.

Please list any allergies:

Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Review of Systems

Please answer every question

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...

Please mark only the symptoms you CURRENTLY are experiencing.

Mark all that apply ---- if no symptoms, please mark "NONE"

General
fever ◯ weight loss ◯ persistent infections ◯
fatigue ◯ weight gain ◯ NONE ◯

Eyes
visual disturbances ◯ glasses/contacts ◯ NONE ◯

Ear, Nose, and Throat
hearing loss ◯ sinus pain ◯
seasonal allergies ◯ oral ulcers ◯ NONE ◯

Cardiovascular
chest pain ◯ palpitations ◯ difficulty breathing on exertions ◯
shortness of breath ◯ swelling hands/feet ◯ NONE ◯

Respiratory
difficulty breathing ◯ chronic cough ◯
wheezing ◯ coughing blood ◯ NONE ◯

Breast
mass/lump ◯ breast pain ◯ nipple discharge ◯ NONE ◯

Gastrointestinal
nausea ◯ constipation ◯ bloody stool ◯ indigestion ◯
vomiting ◯ chronic diarrhea ◯ hemorrhoids ◯
change in bowel habits ◯ abdominal pain ◯ excessive gas ◯ NONE ◯

Female Genitourinary (Women Only)
vaginal dryness ◯ painful urination ◯ pelvic pain ◯
urinary frequency ◯ vaginal discharge ◯ painful menstruation ◯ blood in urine ◯
urinary urgency ◯ vaginal itch or burning ◯ menstrual irregularities ◯
excessive urination at night ◯ painful intercourse ◯ urine leakage ◯ NONE ◯

Male Genitourinary (Men Only)
urinary frequency ◯ testicular mass ◯ urine leakage ◯
painful urination ◯ urinary urgency ◯ testicular pain ◯
change in urinary stream ◯ impotence ◯ penile lesions ◯
excessive urination at night ◯ urethral discharge ◯ blood in urine ◯ NONE ◯

Musculoskeletal
joint pain ◯ muscle pain ◯ muscle weakness ◯ NONE ◯

Skin
dry skin ◯ rash ◯ new sore/lesion ◯
change in wart or mole ◯ hives ◯ skin ulcer ◯ NONE ◯

Neurologic
fainting ◯ numbness ◯ seizures ◯
decreased memory ◯ trouble walking ◯ headaches ◯ NONE ◯

Psychiatric
anxiety ◯ frequent crying ◯ fearful ◯
change in sleep pattern ◯ depression ◯ NONE ◯

Endocrine
hair changes ◯ heat intolerance ◯ cold intolerance ◯
hot flashes ◯ NONE ◯

Heme/Lymphatic
easy bruising ◯ excessive bleeding ◯ gland problems ◯ NONE ◯

Do not write, stamp, punch holes or affix a sticker in this area.

Direction of Feed

Personal / Family History

Please answer every question

To reproduce, follow the printing instructions. Do not fold this form.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

TOBACCO USE

What is your smoking status? current (every day) ○ current (some days) ○ previous ○ never ○

At what age did you begin smoking?

If you quit smoking, at what age did you quit?

How many cigarettes do you currently smoke (or did you previously smoke) **per day?**

EXAMPLE
If you started smoking at the age of 21, you would fill in the ovals like this:
10 20 30
1 2 3

10 20 30 40 50 60 70 80 90
1 2 3 4 5 6 7 8 9

How many cigars or pipes do you smoke per week? none ○ <1 ○ 1-2 ○ 3-5 ○ 6-9 ○ 10+ ○

How many cans of smokeless / chewing tobacco do you use per week? none ○ <1/2 ○ 1/2 ○ 1 ○ 2 ○ 3+ ○

Are you exposed to passive (second hand) **smoke?** yes ○ no ○

ALCOHOL USE

How often do you drink alcohol? Number of times: never ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7+ ○ Per: week ○ month ○ year ○

(If you marked "never", please skip ahead to Drug Use section)

What type(s) of alcohol do you drink? beer ○ wine ○ liquor ○

How many drinks do you have per occasion? 1-2 ○ 3-5 ○ 6-9 ○ 10+ ○

How often do you have more than five drinks per occasion? never ○ rarely ○ occasionally ○ frequently ○

DRUG USE

none ○ current ○ previous ○ prefer to discuss with physician ○

HIV HIGH RISK BEHAVIOR?

(HIV Risk Factors: IV drug use, more than one sexual partner, sex with a prostitute, unprotected sexual contact, contact with contaminated injection equipment.)

yes ○ no ○ prefer to discuss with physician ○

HABITS

Caffeine

Type(s) of caffeine: coffee ○ tea ○ soft drinks ○

Drinks per day: occasionally ○ none ○ 1-2 ○ 3-4 ○ 5-6 ○ 7+ ○

Exercise

Type(s) of exercise: bicycling ○ running ○ swimming ○ walking ○ aerobics ○ other ○

Times per week: occasionally ○ none ○ 1-2 ○ 3-4 ○ 5-6 ○ 7+ ○

How often do you wear a seatbelt? always ○ almost always ○ occasionally ○ never ○

Sun Exposure: occasionally ○ frequently ○ rarely ○

Do not write, stamp, punch holes or affix a sticker in this area.

Direction of Feed

Personal / Family History

Please answer every question

To reproduce, follow the printing instructions. Do not fold this form.

PAST MEDICAL HISTORY

Please indicate if YOU have a history of the following:

- ◯ Alcohol Abuse
- ◯ Anemia
- ◯ Anesthetic Complication
- ◯ Anxiety Disorder
- ◯ Arthritis
- ◯ Asthma
- ◯ Autoimmune Problems
- ◯ Birth Defect(s)
- ◯ Bladder Problems
- ◯ Bleeding Disease
- ◯ Blood Clots
- ◯ Blood Transfusion(s)
- ◯ Bowel Disease
- ◯ Breast Cancer
- ◯ Cervical Cancer
- ◯ Colon Cancer
- ◯ Depression
- ◯ Diabetes
- ◯ Growth / Development Disorder
- ◯ Heart Attack
- ◯ Heart Disease
- ◯ Heart Pain / Angina
- ◯ Hepatitis A
- ◯ Hepatitis B
- ◯ Hepatitis C
- ◯ High Blood Pressure
- ◯ High Cholesterol
- ◯ HIV
- ◯ 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 (STD)
- ◯ Skin Cancer
- ◯ Stroke / CVA of the Brain
- ◯ Suicide Attempt
- ◯ Thyroid Problems
- ◯ Ulcer
- ◯ Other Disease, Cancer, or Significant Medical Illness
- ◯ **NONE of the Above**

FAMILY MEDICAL HISTORY

◯ **Family History UNKNOWN** ◯ **NO SIGNIFICANT FAMILY MEDICAL HISTORY**

Please indicate which family members have had these illnesses:	Father	Mother	Brother	Sister	Son	Daughter
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	◯	◯	◯	◯	◯	◯
Lung / Respiratory Disease	◯	◯	◯	◯	◯	◯
Migraines	◯	◯	◯	◯	◯	◯
Osteoporosis	◯	◯	◯	◯	◯	◯
Rectal Cancer	◯	◯	◯	◯	◯	◯
Seizures / Convulsions	◯	◯	◯	◯	◯	◯
Severe Allergy	◯	◯	◯	◯	◯	◯
Stroke / CVA of the Brain	◯	◯	◯	◯	◯	◯
Thyroid Problems	◯	◯	◯	◯	◯	◯
Other Cancer	◯	◯	◯	◯	◯	◯

◯ Mother, Grandmother, or Sister developed heart disease before the age of 65

◯ Father, Grandfather, or Brother developed heart disease before the age of 55

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Using Adobe Acrobat Reader 8.0 or later

Surgeries

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...

Please mark all surgeries you have had.

◯ I have had no Surgeries. (no need to complete questionnaire)

◯ Anal Fissure Repair	◯ Low Back Disc Surgery	◯ Tonsillectomy	◯ Deviated Nose Septum
◯ Appendectomy	◯ Neck Disc Surgery	◯ Ulcer Surgery	◯ Tubal Ligation
◯ Hemorrhoidectomy	◯ Sinus Surgery	◯ Vasectomy	

Prostate Surgery	◯ TURP	◯ Removal		
Gallbladder Surgery	◯ Open	◯ Laparoscopic		
Colon Polyp Removal	◯ Open	◯ Colonoscopy		
Colon Removal	◯ Partial	◯ Complete		
Hysterectomy (due to cancer)	◯ Partial	◯ Complete		
Hysterectomy (not due to cancer)	◯ Partial	◯ Complete		
Spinal Fusion	◯ Neck	◯ Lower Back		
Spinal Decompression	◯ Neck	◯ Lower Back		
Dilation and Curettage (D&C)	◯ Single	◯ Multiple		
Lung Surgery	◯ Left	◯ Right	◯ Both	
Kidney Removal	◯ Left	◯ Right	◯ Both	
Cataract Surgery	◯ Left	◯ Right	◯ Both	
Breast Cancer Lump Removal	◯ Left	◯ Right	◯ Both	
Mastectomy	◯ Left	◯ Right	◯ Both	
Breast Reconstruction	◯ Left	◯ Right	◯ Both	
Breast Reduction	◯ Left	◯ Right	◯ Both	
Ovary Removal	◯ Left	◯ Right	◯ Both	
Carpal Tunnel Surgery	◯ Left	◯ Right	◯ Both	
Rotator Cuff Repair	◯ Left	◯ Right	◯ Both	
Arthroscopic Shoulder Surgery	◯ Left	◯ Right	◯ Both	
Hip Fracture & Surgery	◯ Left	◯ Right	◯ Both	
Total Hip Replacement	◯ Left	◯ Right	◯ Both	
Total Knee Replacement	◯ Left	◯ Right	◯ Both	
Arthroscopic Knee Surgery	◯ Left	◯ Right	◯ Both	
Foot Surgery	◯ Left	◯ Right	◯ Both	
Leg Circulation Surgery	◯ Left	◯ Right	◯ Both	
Mastoidectomy	◯ Left	◯ Right	◯ Both	
Thyroid Removal	◯ Left	◯ Right	◯ Total	◯ Partial
Breast Biopsy	◯ Left	◯ Right	◯ Both	◯ Multiple times
Carotid Artery Surgery	◯ Left	◯ Right	◯ Both	◯ Multiple times
Open Inguinal Hernia Surgery	◯ Left	◯ Right	◯ Both	◯ Multiple times
Laparoscopic Inguinal Hernia Surgery	◯ Left	◯ Right	◯ Both	◯ Multiple times
Caesarean Section	◯ 1	◯ 2	◯ 3 or more	
Heart Valve Replacement	◯ Mitral	◯ Aortic	◯ Tricuspid	◯ Unknown Valve
Heart Bypass Surgery	◯ 1 vessel	◯ 2 vessels	◯ 3 vessels	◯ 4 or more vessels
	◯ Unknown number of vessels			