ConciergeMED
Tailored healthcare in your home℠

PATIENT INFORMATION SHEET
(PLEASE PRINT)

Date:_____

Last Name: _____First_____MI_____

Address:_____City/State/Zip_____

Home Phone:_____Cell:_____Work:_____

Email Address:_____

Name of Employer:_____

Driver's License No._____Date of Birth:_____Age:_____

Social Security No._____ Sex: Male ____ Female_____

IN THE EVENT OF AN EMERGENCY, PLEASE NOTIFY:

Name:_____Relationship:_____
Address:_____Phone:_____

Name:_____Relationship:_____
Adress:_____Phone:_____

I WOULD PREFER TO BE TREATED AT _____HOSPITAL

WERE YOU REFERRED BY ANYONE? _YES _NO

_____
Patient Signature/Date

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VOLUNTARY CARE
PATIENT CONSENT TO TREAT FORM

*NAME:*_____ *DOB:*_____ *DATE:*_____

*SSN:*_____ *PHONE:*_____

*HOME ADDRESS:*_____

I hereby consent to the provision of diagnosis, care, and/or treatment by ***Rendall L. Northcutt, FNP-C,*** *and I hereby acknowledge that such consent will remain in effect unless and until I cancel such consent in writing.*

I hereby acknowledge and confirm that I am mentally capable of giving informed consent to the provision of the diagnosis, care and/or treatment and am not subject to duress or undue influence.

I HEREBY ACKNOWLEDGE AND UNDERSTAND THAT, BY SIGNING THIS VOLUNTARY CARE PATIENT CONSENT FORM, I AM GIVING INFORMED CONSENT TO THE PROVISION OF DIAGNOSIS, CARE, AND/OR TREATMENT BY RENDALL L. NORTHCUTT, FNP-C AND CANNOT BRING A TORT OR OTHER SIMILAR ACTION, INCLUDING AN ACTION ON A MEDICAL, DENTAL, CHIROPRACTIC, OPTOMETRIC OR OTHER HEALTH-RELATED CLAIM, AGAINST RENDALL L. NORTHCUTT, FNP-C UNLESS THE ACTION OR OMISSION OF RENDALL L. NORTHCUTT, FNP-C CONSTITUTES WILLFUL OR WANTON MISCONDUCT.

AS A PATIENT OF RENDALL L. NORTHCUTT, FNP-C, I UNDERSTAND THAT RENDALL L. NORTHCUTT, FNP-C PARTICIPATE IN THE STATE OF TEXAS PRESCRIPTION MONITORING PROGRAM IN ORDER TO, AS NEEDED, VERIFY MEDICATION USAGE OF PATIENTS.

_____ _____

Signature of Patient or Person Authorized to Consent *Date*

_____

Relationship (if not patient)

****If this Consent for Treatment is signed by someone other than the patient, it must be signed in the patient's presence.***

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Medical Questionnaire

*DATE:*_____ *NAME:*_____

*DOB:*_____

*CURRENT COMPLAINT(S):*_____

_____

_____

MEDICAL HISTORY: *Check all that apply (past and present)*

_ High Blood Pressure
_ Diabetes
_ High Cholesterol
_ Thyroid Problems
_ Heart Disease/Angina
_ Irregular Heartbeat
_ Osteoporosis
_ Stroke
_ Acid Reflux/Hiatal Hernia
_ Stomach Ulcers/Gastritis
_ Cancer Type_____
_ Diverticulosis/diverticulitis
_ Colitis
_ Constipation
_ Hemorrhoids
_ Colon Polyps
_ Hayfever/allergies
_ Asthma
_ Pneumonia
_ Sinus infections (frequent)
_ Migraines/headaches
_ Seizures/epilepsy
_Tremor
_ Parkinson's disease
_ Dementia/memory loss
_ Dizziness/fainting
_ Anemia
_ Insomnia
_ Heart murmur
_ Back pain
_ Arthritis/rheumatism
_ Gout
_ Varicose veins
_ Gallbladder problems
_ Kidney stone
_ Kidney disease
_ Urine leakage
_ Blood in urine
_ Prostate problems
_ Hepatitis/jaundice
_ Liver disease
_ Menstrual problems
_ Abnormal Pap smear
_ PMS
_ Other_____

_ Depression
_ Anxiety/nervousness
_ Glaucoma
_ Macular degeneration

SURGICAL HISTORY: *Check all that you have had and give dates*

_ *Tonsils/adenoids*_____
_ *Appendix*_____
_ *Gallbladder*_____
_ *Hernia*_____
_ *Sinuses*_____
_ *Thyroid*_____
_ *Hysterectomy*_____
_ *Ovaries*_____
_ *Tubal ligation*_____
_ *Prostate*_____
_ *Bladder*_____
_ *Colon*_____
_ *Breast*_____
_ *C-section*_____

_ *Heart*_____
_ *Carotid*_____
_ *Spine*_____
_ *Joints*_____
_ *Other*_____

MEDICATIONS: *Include all prescription and nonprescription medication including pills, eye drops, vitamins, pain relievers, cough and cold remedies even if used only occasionally. You may also provide a copy of your medication list.*

NAME *STRENGTH* *NUMBER TAKEN PER DAY*

_____
_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES:

MEDICATION: *REACTION:*

_____
_____
_____

_____

_____

*OTHER ALLERGIES:*_____ *REACTION:*_____

VACCINATIONS *Check all that apply and give dates of last given*

_*Tetanus*_____ _ *Hepatitis B*_____ _*TB Skin test* _____
_ *Pneumonia*_____ _ *Chickenpox*_____ _ *Other*_____
_ *Influenza (flu)*_____ _*Measles*_____

Have you ever had a blood transfusion? _ *No* _*Yes* *When?* _____

SOCIAL HISTORY (HABITS): *Check all that apply*

SMOKING: _*Current* _*Quit* *When?*_____ *How long smoked?*_____ *Packs per day*____

ALCOHOL: _*Current* _*In Past/Quit* *When?*_____ *Drinks Per Day*_____ *How long?*___

CAFFEINE: _ *Coffee* _ *Tea* _ *Colas* _ *Chocolate* _*Other*_____

EXERCISE: _ *Yes* _*No* *Type:*_____ *How Often?*_____

DIET: _*Yes* _*No* *Type:* _*Diabetic* _*Low Fat* _*Low Salt* _*Other*

OCCUPATION: *Type:*_____ *Currently employed?* _*Yes* _*No* _*Retired*

Have you ever used social or recreational drugs? _*Yes* _*No* *When?*_____

FAMILY HISTORY: (Check all that apply)	*Father*	*Mother*	*Children*	*Siblings*	*Grandparents* paternal/maternal
High blood pressure					
Diabetes					
Thyroid disease					
Heart disease					
Stroke					
Osteoporosis					
Asthma					
Allergies/Hayfever					
Mental Illness					
Cancer					
*Other*_____					

FEMALES ONLY:

Pregnant _Yes _No *Menopause _Yes _No*

Planning Pregnancy _Yes _No *Menopause Symptoms _Yes _No*

Birth Control Method:_____ *First Day of Last Menses:_____*

Menstrual Flow: _Regular _Irregular _Heavy _Pain/cramps

Length of Cycle:_____ *Days of flow:_____*

Number of Pregnancies:_____ *Live Births:_____* *Miscarriages:_____*
Abortions:____ *D&C:_____*

TEST HISTORY: *Check all that apply and give last date of each*

_Pap Smear _____ _ Normal _ Abnormal

_Mammogram _____ _ Normal _ Abnormal

_ EKG_____ _Treadmill _____ _Heart Catheterization_____

_ Chest Xray_____ _ Other Xray_____

_ Colonoscopy/flexible sigmoidoscopy_____ _Normal _Abnormal

_Upper GI series/endoscopy_____

_ Blood tests_____

_ Other _____

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HIPPA AUTHORIZATION TO RELEASE INFORMATION

*PATIENT NAME:*_____ *DOB:*_____ *SSN#:*_____

*ADDRESS:*_____ *TELEPHONE:*_____

*CELL/ALTERNATIVE PHONE:*_____

I authorize the use or disclosure of the above-named individual's health information as described below to the following individual or organization:

ConciergeMED,PLLC
Rendall Northcutt, FNP-C
Phone (903) 372-4112~ Fax: (888)-856-4752

Any and all medical records held by ***Rendall Northcutt, FNP-C,*** *for the purpose of sharing medical information with other providers and pharmacy.*

ALL *medical records are authorized to be disclosed* ***OR*** *as checked below:*

_____ *a. Problem List*

_____ *b. Medication/Pharmacy Listings*

_____ *c. List of Allergies*

_____ *d. Most Recent History/Physical*

_____ *e. Discharge Summary*

_____ *f. Laboratory Results*

_____ *g. Consultation/Counseling Reports*

_____ *h. NO INFORMATION TO BE RELEASED*

I understand that I have the right to revoke this authorization at any time and must do so in writing. I understand that authorizing disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I further authorize ***Rendall Northcutt, FNP-C*** *to leave confidential medical information or test results, as needed, on my voicemail.*

I authorize the following individuals to receive my healthcare information as previously stated:

_____	_____
Name	*Relationship to Patient*
_____	_____
Name	*Relationship to Patient*
_____	_____
Name	*Relationship to Patient*
_____	_____
Patient Signature	*Date*
_____	_____
Employee Witness Signature	*Date*