Patient Name: _____ Date of Birth _____

Address: _____ City: _____ Zip: _____

Phone: (Home) _____ ☐Preferred (Cell) _____ ☐Preferred

Email: _____ Marital Status: M S D W

Race: _____☐Decline to answer Ethnicity: _____☐Decline to answer

Occupation: _____ Employer: _____

How did you hear about Helical Health? _____

RESPONSIBLE PARTY
Who has financial responsibility for medical bills? ☐ Self ☐ Parent or Guardian: Name: _____Phone: _____ Relationship to patient: _____ Address: _____
Do you have a Medical Power of Attorney or Legal Guardian? Yes / No If yes, please fill out: Name: _____ Phone: _____ Address: _____ Relationship to patient: _____

INSURANCE: Please give insurance card(s) to front desk to be scanned.	
Primary Insurance: _____ Subscriber #: _____ Group #: _____ Who is the primary insured? ☐ Self ☐ Other: Name: _____ DOB: _____ Relationship: _____	Secondary Insurance: _____ Subscriber #: _____ Group #: _____ Who is the primary insured? ☐ Self ☐ Other: Name: _____ DOB: _____ Relationship: _____

_____ _____

Signature of Patient or Legal Guardian Date

EMERGENCY CONTACT		
Name:	Phone:	Relationship:
Address:	☐ Check if same address as patient ☐ Check if Helical Health can discuss medical information with emergency contact	

FRIENDS, FAMILY, CAREGIVERS, GUARDIANS
List people who can talk with Helical Health about your health information:

Name	Phone	Relationship	Any restrictions?

PHARMACIES
Helical Health uses e-prescriptions and can import pharmacy records for accuracy.

Name	Address	Phone
Primary		
Secondary		

SPECIALISTS and/or PRIOR PCPs
List providers that you want added to your chart in order to facilitate coordination of care:

Name	Specialty	Phone	Fax
	Previous PCP Last seen:		

ADVANCE DIRECTIVES

☐ I currently have the following Advance Directives. [Please give copies to be scanned.]
- ☐ Living will
- ☐ Medical Power of Attorney
- ☐ Do Not Resuscitate order

☐ I do NOT have any Advance Directives at this time.

PRIVACY POLICY/USE, DISCLOSURE OF PHI & eHx CONSENT

I hereby give my consent for Helical Health, PLLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). The Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the full policy prior to signing this consent; a copy is also available on helicalhealth.com.

I consent to Helical Health's use and disclosure of my PHI to carry out TPO. Helical Health may leave a message on voicemail, mail or email any items that assist with TPO (appointment reminders, billing, or clinical care). I have the right to request how Helical Health discloses my PHI to carry out TPO, however the practice is not required to agree to my requested restrictions.

I give my consent to opt-in to the eHx Program which allows the Southwestern Health Resources Community to access my information.

I may revoke my consent in writing except to the extent that the practice has already made disclosures upon my prior consent. If I do not sign this consent or later revoke it, treatment may be declined.

_____ _____

Signature of Patient or Legal Guardian Date

HelicalHealth

CONSENT TO TREAT

I grant permission to the employees of Helical Health, PLLC to render routine outpatient care to carry out provider's orders. I understand that medicine and surgery is not an exact science and there is no guarantee that the outcome of my treatment will be what I want it to be.

Accidental Exposure of Health Care Worker

I understand that Texas law provides, and I agree, that if any HEALTH CARE worker is exposed to my blood or other bodily fluid, to allow Helical Health, PLLC to perform tests on my blood or other bodily fluid to determine the presence of any communicable disease; including but not limited to Hepatitis, Human Immunodeficiency Virus and syphilis. I understand that such testing is necessary to protect those who will be caring for me. I understand that the results of tests taken under these circumstances do not become a part of my medical record.

Insurance Coverage and Financial Responsibility

MEDICARE BENEFITS: As a Medicare patient, I certify that the information given by me applying for payment under the Social Security Act is correct. I request payment of authorized benefits be made on my behalf. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.

OTHER INSURANCE: I hereby authorize and transfer any insurance or Medicaid benefit payable to or for my benefit for the payment of such services rendered. I have reported to Helical Health, PLLC a listing of my additional coverage. I understand that Helical Health, PLLC will not file a claim for any insurance not reported before the service is rendered.

I understand that my insurance may be billed for telephone calls and other non-face-to-face encounters. I also understand that I may incur a fee for no shows or appointments cancelled in under 24 hours.

I understand that regardless of any assigned insurance benefits, I am responsible for the total allowable charges for services rendered. Any amount remaining on this account after applicable insurances have been filed and settled will be due and payable upon receipt of statement.

Release of Information

I authorize Helical Health, PLLC to release any medical information pertaining to my diagnosis and treatment through Helical Health, PLLC to (1) representatives of local, state or federal agencies in accordance with the law, (2) Medicare, (3) Medicaid, (4) my insurance company representative or (5) any person or entities financially responsible for my care. I further authorize release of this information to health care providers associated with my care outside of Helical Health, PLLC to facilitate further health care. All records concerning my care remain the property of Helical Health, PLLC. All records are confidential.

I request that this acknowledgement be in effect until revoked in writing for outpatient services rendered through Helical Health, PLLC.

_____ _____

Signature of Patient/Legal Guardian Date

HelicalHealth

PAIN MANAGEMENT AGREEMENT

Have you had a narcotic medication filled in the past year?	Yes / No

The purpose of this Agreement is to prevent misunderstanding about certain medicines you will be taking for pain management. This is to help both you and your doctor comply with the law regarding controlled pharmaceuticals.

- I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.
- I understand that if I break this Agreement, my doctor will stop prescribing these pain-control medicines.
- I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.
- I will not use any illegal controlled substances, including marijuana, cocaine, etc.
- I will not share, sell or trade my medication with anyone.
- I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or antianxiety medicines form any other doctor.
- I will safeguard my pain medicine from loss or theft. Lost or stolen medicines may not be replaced.
- I allow Helical Health to pull my prescription history.

I agree to use the primary pharmacy listed on the Communications page for filling prescriptions for all of my controlled medicines.

- I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
- I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine.
- I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time. If my pain is not well controlled, I will contact my doctor to discuss alternatives.
- I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered.

_____ _____

Signature of Patient/Legal Guardian Date

_____ _____

Signature of Provider Date

Name: _____ Date:_____

PERSONAL MEDICAL HISTORY (Check all that apply)			*More detailed review on page 7
☐ Cancer	☐ Kidney disease	☐ Anxiety/depression	
☐ Diabetes	☐ Liver disease	☐ Autoimmune disorder	
☐ High blood pressure	☐ Thyroid disease	☐ Stroke	
☐ Heart disease	☐ Skin condition	☐ Substance abuse	
☐ Lung disease	☐ Eye disorder	☐ Sexually Transmitted Disease	
☐ Other:		☐ Nothing to report	

SURGERIES AND HOSPITALIZATIONS	Date	Location/facility

VACCINATION HISTORY (list most recent dates, provide shot records for your chart, or write N/A)				
Covid: Brand:_____ Dose 1:	Dose 2:	Dose 3:	Dose 4:	
Covid Variant:	Tetanus or TdaP:			
Flu:	Pneumonia:			
Shingles:	Other:			

FAMILY HISTORY	Mom	Dad	Bro	Sis	Child	MGM	MGF	PGM	PGF
Write Alive (A) & birth year or Deceased (D) for each person	Yr:	Yr:							
Alcoholism/drug abuse									
Anxiety									
Bleeding disorder									
Cancer List type(s):									
COPD/emphysema									
Depression									
Dementia									
Diabetes									
Heart disease									
High blood pressure									
High cholesterol									
Kidney disease									
Thyroid disease (write low or high)									
Stroke									
Other:									

ALLERGIES	Reaction

MEDICATIONS	Dose	Times per day	Why do you take it?

MAINTENANCE HEALTH	Date or write N/A	Facility/Provider	Abnormal result?
Last colonoscopy			
Last cholesterol/lipids			
Last dental visit			
Last HgbA1C			
Last bone density (DEXA)			
Last mammogram			

WOMEN'S HEALTH	Date	Facility/Provider	Abnormal result?
Last PAP			
Last menstrual cycle: _____ Age at first menses: _____ Are your periods monthly? _____ Heavy, medium, or light flow? _____ Do you get menstrual cramps? _____ Age at menopause: _____		Number of pregnancies: _____ Number of live births: _____ Pregnancy complications: _____ Method of birth control: _____ Do you get hot flashes? _____	
Do you do a breast self-exam? Yes / No If yes, have you had any concerns?			

MEN'S HEALTH	Date	Facility/Provider	Abnormal result?
Last PSA			
Last rectal exam			
Do you do a testicular self-exam? Yes / No If yes, have you had any concerns?			
Do you do a chest/breast self-exam? Yes / No If yes, have you had any concerns?			

REVIEW OF SYSTEMS: Check any that have occurred in the past month.		
GENERAL/SLEEP	CARDIOVASCULAR	GENITOURINARY
☐ Fatigue ☐ Fever/chills ☐ Weight loss/gain ☐ Tattoos ☐ Daytime sleepiness ☐ Sleeping difficulty ☐ Snoring ☐ Stop breathing while sleeping	☐ Heart attack/Angina ☐ Chest pain ☐ Leg/ankle swelling ☐ Palpitations/Irregular beat ☐ Left arm pain ☐ Heart murmur ☐ Varicose veins ☐ Cold feet/leg pain while walking	☐ Difficulty/painful urinating ☐ Urination control/frequency/ urgency/overnight urination ☐ Blood in urine/urine infections ☐ Weak urine stream ☐ Decreased emptying feeling ☐ Erectile dysfunction ☐ Kidney stones ☐ Prostate issues
EAR, NOSE, THROAT	RESPIRATORY	PSYCHIATRIC
☐ Hearing loss/Ear ringing ☐ Mouth sores/gum problems ☐ Sore throat/Hoarseness ☐ Trouble swallowing ☐ Sinus problems	☐ Shortness of breath ☐ Cough ☐ Coughing up blood ☐ Wheezing ☐ Pneumonia	☐ Confusion ☐ Memory loss ☐ Mood changes ☐ Nervousness/Anxiety ☐ Mental illness
REPRODUCTIVE	GASTROINTESTINAL	HEMATOLOGIC
☐ Breast lump ☐ Irregular periods ☐ Testicular lump ☐ Change in sexual drive ☐ Discharge ☐ Pelvic pain	☐ Nausea/vomiting ☐ Reflux or heartburn ☐ Diarrhea or constipation ☐ Bloody/black, tarry stool ☐ Ulcers ☐ Hemorrhoids	☐ Blood clots ☐ Easy bleeding or bruising ☐ Blood transfusions (ever) ☐ Swollen lymph nodes ☐ Anemia ☐ Nose bleeds, significant
ENDOCRINE	MUSCULOSKELETAL	ALLERGY/IMMUNOLOGY
☐ Cold intolerance ☐ Heat intolerance ☐ Change in thirst or hunger ☐ Neck swelling	☐ Muscle/Joint Pain, Arthritis ☐ Joint swelling or stiffness ☐ Back pain ☐ Foot pain/difficulty walking ☐ Bone/joint injury	☐ Environmental allergies ☐ Food allergies ☐ Immunocompromised ☐ Hives ☐ Allergy testing done ☐ Allergy shots
SKIN	EYES	NEUROLOGIC
☐ Dry, itchy skin; Eczema ☐ New or changed mole ☐ Rash ☐ Psoriasis	☐ Blurry vision ☐ Double vision ☐ Drainage or redness ☐ Eye pain	☐ Dizziness/Fainting ☐ Headaches ☐ Numbness/tingling ☐ Seizures/Tremor

LIFESTYLE	
Caffeine: How much do you drink per day?	☐ Check if you wish to discuss quitting or have other concerns ☐
Tobacco/Nicotine: Do you smoke? Yes No (check any that you use or have used in past) ☐ Cigarette smoking: _____packs/day for _____years ☐ Pipe or cigar smoking. ☐ Vaping ☐ Snuff/chewing tobacco	☐ Check if you wish to discuss quitting or have other concerns If quit, how long ago?
Alcohol: How much do you drink per day? _____ **If quit, how long ago?	☐ Check if you wish to discuss quitting or have other concerns
Drugs: Have you used any street drugs in the past 12 months? Yes / No. What kind?	☐ Check if you wish to discuss quitting or have other concerns
Sexual Activity: Are you sexually active? Yes No How many current partners? ____ Number of partners in your lifetime? _____	☐ Check if you have any concerns to discuss with the doctor.
Exercise: How many times per week? _____ What kind of exercise?	
Nutrition: Do you have any dietary preferences?	
Have you fallen in the last year? Yes No If yes, how many times? _____ Did you hurt yourself? Yes No	