

1770 SH-46 W, Ste 1201
New Braunfels, TX 78132
P: (830) 730-4125

1762 E Common St
New Braunfels, TX 78130
P: (830) 730-8580

1423 FM 2673
Canyon Lake, TX 78133
Phone: (830) 428-3970

221 Hunters Village, Ste B
New Braunfels, TX 78132
Phone: (830) 627-8300



1400 N State Hwy 123
San Marcos, TX 78666
P: (512) 396-3663

944 S State Hwy 123 BYP
Seguin, TX 78155
P: (512) 396-3663

14100 Ranch Rd 12
Wimberley, TX 78676
P: (512) 847-0300

NEW PATIENT QUESTIONNAIRE

Please fill out this form as thoroughly as possible, printing all responses clearly. All information is completely confidential and will not be released unless you authorize us to do so.

PERSONAL INFORMATION **Please provide a form of identification (Driver's License)						
Last Name	First	Middle	Prefix	Birthdate	Sex	
					M	F
Mailing Address		City	State	Zip	Social Security Number	
Home/Mobile Phone		Email Address				
Emergency Contact		Relationship	Home/Mobile Phone	Work Phone		
INSURANCE INFORMATION**Please provide a copy of the Insurance Card(s)						
Name of Person Responsible for Insurance Account:		Relation to Patient:		Insurance Company(ies)		
Birthdate:	Soc. Sec. Number:	Insurance Member ID #		Insurance Group #		

MEDICAL HISTORY (✓) Check conditions you have or have had in the past			
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Chemical dependence	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Psychiatric care
<input type="checkbox"/> Anemia	<input type="checkbox"/> Depression	<input type="checkbox"/> Herpes	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Seasonal allergies
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Sexual difficulty
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Sexually transmitted infection
<input type="checkbox"/> Autoimmune disease	<input type="checkbox"/> Epilepsy/ Seizures	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Skin rash
<input type="checkbox"/> Bleeding/Clotting disorder	<input type="checkbox"/> Erectile dysfunction	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Sleep apnea
<input type="checkbox"/> Bone/Joint disorder	<input type="checkbox"/> GERD (reflux)	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Breast lump	<input type="checkbox"/> Goiter	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Thyroid problem
<input type="checkbox"/> Cancer (see below)	<input type="checkbox"/> Gout	<input type="checkbox"/> Peripheral vascular disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Headaches	<input type="checkbox"/> PPD positive	<input type="checkbox"/> Urinary incontinence
<input type="checkbox"/> CAD/Heart disease	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Prostate problem	<input type="checkbox"/> Vaginal infection
<input type="checkbox"/> Other (please describe):			
If you have/had cancer, please name type (s) and describe treatment with corresponding dates in the space below:			
Date of last physical exam:		Former primary care provider:	
Reason for today's visit:			
Please describe any symptoms/complaints that you would like to discuss with your primary care provider at today's appointment:			

ALLERGIES			
No Known Allergies	Yes, I have the following medication and/or food allergies. Please describe your reaction to each medication/food listed:		
HOSPITALIZATIONS, SERIOUS ILLNESS, INJURIES, SURGERIES			
YEAR	LOCATION	REASON FOR HOSPITALIZATION / DESCRIBE SERIOUS ILLNESS OR INJURY	
MEDICATIONS <i>List all medications, vitamins, and supplements. Write dosage and frequency for each medication. *Please attach additional sheets if necessary.</i>			
Preferred Pharmacy & Address:			Phone:
Secondary Pharmacy & Address:			Phone:
Health Maintenance History: <i>Record last date and result</i>			
Colonoscopy:		Cardiac Testing:	
Mammogram:		Abdominal US:	
Bone Density Testing:		Eye Exam:	
Pap Smear or Prostate Exam:		Pneumovax23:	Prevnar13:
Low Dose CT Lung:		Influenza Vaccine:	
Family Medical History			
Father			
Mother			
Brother (s)			
Sister (s)			
Other			
Health Habits <i>Mark (X) conditions you use and how much/how many hours</i>			Occupation:
Tobacco use:	Alcohol use:	Description:	
Illegal drug use:	Other:		

**** Please review our Clinical Policies and Agreements****

Your signature below signifies that you have read and acknowledge the policies regarding:

- 1) Consent for Treatment
- 2) Financial Responsibility
- 3) Release of Information
- 4) Benefit Assignment
- 5) About Physician Assistants
- 6) Acknowledgement
- 7) Notice of Privacy Practices

I attest that the above information is correct to the best of my knowledge.

I also certify that I, and/or my dependent(s), have insurance coverage with the insurance(s) provided and assign all insurance benefits, if any, directly to PAK MEDICAL GROUP. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The clinicians assigned to the PAK MEDICAL GROUP may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below:

Signature of Patient, Parent, Guardian, or Personal Representative

Date

Printed name of Patient, Parent, Guardian, or Personal Representative

Relationship to Patient