Sea Base Medicine

NEW PATIENT INFORMATION FORM

Phone: 817-953-3420
Fax: 817-953-3418
SeaBaseMedicine.com

GENERAL PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____

City: _____ State: _____ Zip Code: _____

Main Contact Number: _____ Alternate: _____

Email: _____ Referred by: _____

Sex: ☐ Male ☐ Female Race: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Occupation: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Phone Number: _____

Relationship to Patient: _____ Okay to leave voicemail? ☐ YES ☐ NO

PHARMACY INFORMATION

Preferred Pharmacy: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

*Please allow **24 - 72 hours** for responses to phone calls, voicemails and electronic requests made for prescription refills. We reserve the right to refuse refill or prescription change requests for any reason, including but not limited to: medically inappropriate requests, controlled and dangerous medications, or need for follow up or annual visit prior to refill. It is illegal in the state of Texas for us to continually send in medications if you have not been seen in the **last year**, and we require **annual visits** to ensure timely and accurate refills. **If your preferred pharmacy changes, it is your responsibility to let us know, or medications will continue to be sent to the pharmacy on file.***

(INITIAL): _____ I acknowledge the above statement.

INSURANCE INFORMATION

Primary Insurance Provider: _____ Policy/ID#: _____

Name of Policy Holder: _____ DOB: ____/____/_____ Group/Acct #: _____

Optional:

Secondary Insurance Provider: _____ Policy/ID#: _____

Name of Policy Holder: _____ DOB: ____/____/_____ Group/Acct #: _____

Sea Base Medicine
MEDICAL HISTORY

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Patient Name: _____ Date of Birth: _____/_____/_____

Reason for Visit Today: _____

KNOWN MEDICAL HISTORY

Please list any known health conditions you have been diagnosed with, including if you see a specialist for any condition. This includes things that you **may or may not take medication for,** such as diabetes, high blood pressure, high cholesterol, heart attack/stroke history, atrial fibrillation, pacemaker, heart failure, cancer (active or history of/in remission), anxiety, depression, ADHD, thyroid issues, bleeding disorders, asthma/COPD), acid reflux, kidney stones, prostate issues, seizure disorder, etc.

CONDITION	MANAGED BY (if other than PCP)	APPROX. DATE DIAGNOSED

FAMILY HISTORY

Is there a history in your family of the following conditions? *(Include grandparents, parents, siblings, & children only)*

CONDITION	YES	NO	AFFECTED RELATIVE(S)
Heart attack			
Stroke			
Cancer (include type)			
Diabetes (include type)			
Psychiatric disease (specify)			
Other significant disease			

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MEDICAL HISTORY, CONTINUED

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OB/GYN HISTORY

Number of Pregnancies: _____ Number of Deliveries: _____ Last Menstrual Cycle: _____

SOCIAL HISTORY

SMOKING HISTORY

Are you an active (current) cigarette smoker? ☐ YES ☐ NO

If YES: I smoke an average of _____ (cigarettes / packs) per (day / week).

Are you an active (current) nicotine vaper/ecig user? ☐ YES ☐ NO

If YES: Estimate your nicotine intake: _____ per (day / week).

Have you ever smoked cigarettes/vapes/ecigs in the past? ☐ YES ☐ NO

If YES: I smoked an average of ____ (cigarettes / packs) per (day / week) for ____ years. I quit in _____ (year).

Do you use any other tobacco products? ☐ YES Specify: _____ ☐ NO

Are you interested in quitting? ☐ YES ☐ NO ☐ N/A

ALCOHOL AND DRUG HISTORY

Do you currently drink alcohol regularly? ☐ YES ☐ NO

If YES: I have approximately _____ standard drinks (beer / liquor / wine) per (day / week).

Have you ever been diagnosed with alcoholism? ☐ YES ☐ NO

Do you use any recreational drugs regularly?

If YES: Please specify: _____ How often? _____

Have you ever used intravenous drugs? ☐ YES ☐ NO

PREVENTATIVE HEALTH

45+: Last colonoscopy (date): _____ 40+ F: Last mammogram (date): _____

Do you have the following vaccinations? (check if yes) ☐ Flu ☐ COVID ☐ Tetanus (Tdap) within last 10 years

If 50+: ☐ Shingles 2-shot series (year _____) If 65+: ☐ Pneumococcal (PCV20) (year _____)

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ALLERGIES, MEDICATIONS, SURGERIES, HOSPITALIZATIONS

DRUG ALLERGIES:

Please include medications, medication classes or medical supplies (latex, adhesive, iodine) or ☐ **NONE KNOWN**

Allergic to: _____ Reaction: _____
Allergic to: _____ Reaction: _____
Allergic to: _____ Reaction: _____
Allergic to: _____ Reaction: _____

CURRENT MEDICATIONS:

Please include daily medications, as needed medications, and over-the-counter medications that you regularly use.

MEDICATION NAME	DOSE	HOW OFTEN	REASON FOR TAKING	PRESCRIBING PROVIDER

PREVIOUS SURGERIES OR HOSPITALIZATIONS:

DATES	SURGERY/HOSPITALIZATION	FACILITY

1631 Lancaster Drive, Suite 330, Grapevine, TX 76051

Sea Base Medicine

PATIENT AUTHORIZATION (1 OF 2)

Please read, initial, and sign below as indicated.

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(Initial) _____ **Consent to Treat:** I hereby authorize employees and agents (including physicians, physician assistants, and nurse practitioners) of this medical office to render routine medical care to me, the patient indicated on this form, and to fulfill the orders of the physicians (including consultants, associates, and assistants of the physician's choice). The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, medical care will not be provided except in case of an emergency.

(Initial) _____ **Financial Responsibility:** I hereby authorize payments from Medicare and/or other insurance companies of medical benefits directly to Sea Base Medicine and/or the attending physician for services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or insurance company any information needed to determine these benefits or the benefits payable for related services. I appoint Sea Base Medicine to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment. I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to Sea Base Medicine. I further understand that, should my account become delinquent, I shall pay the reasonable fees or collection expenses, if any. I acknowledge that I am fully responsible for supplying correct insurance information, billing information, and payment of any services not covered or approved by my insurance carrier. The duration of this authorization is indefinite and continues until revoked in writing.

(Initial) _____ **Release of Information:** Authorization is hereby granted to release information contained in my medical record as may be necessary for medical treatment or to process and complete my insurance claims. I understand that this release of information may include information regarding communicable diseases such as HIV (human immunodeficiency virus) and AIDS (acquired immune deficiency syndrome). The duration of this authorization is indefinite and continues until revoked in writing.

(Initial) _____ **Financial Policies:** I have received and read a copy of the financial policies from Sea Base Medicine.

(Initial) _____ **Acknowledgement of Receipt of the Notice of Health Information Practices for Sea Base Medicine:** The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care. Sea Base Medicine and associated physicians are committed to securing the privacy of your health information. We have made available to you a copy of the notice which provides information about how its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. By signing this form, you acknowledge that you have received a copy of Sea Base Medicine's Notice of Health Information Practices.

I have read all of the above and agree to these terms.

_____ _____/_____/_____

Patient's Full Name (Printed) Date of Birth

_____ _____

Signature of Patient or Legal Guardian (if minor) Date

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PATIENT AUTHORIZATION (2 OF 2)

Please read, initial, and sign below as indicated.

(Initial) _____ **Phone Calls:** By providing contact information, I hereby authorize Sea Base Medicine, its assignees, and third party collection agents to do the following: use the contact information I have provided to communicate with me; to place calls to my home / cellular / employment telephone; to leave voicemails or text messages; and to use pre-recorded / artificial voice messages and/or auto-dialing devices in connection with any communication to me.

(Initial) _____ **Missed Appointments:** If you cannot keep your appointment, you will need to reschedule your appointment 24 hours in advance. This will allow us to schedule another patient in that time slot. If any office visit appointment is no-showed, canceled with less than 24 hours' notice, or needs to be rescheduled due to late arrival, a charge of $35 (thirty-five dollars) may be billed to your account. This charge is not payable by your insurance company. If multiple appointments are missed and we identify a problem with you keeping appointments, we reserve the right to refuse to continue to provide care for you at this office.

(Initial) _____ **Late Policy:** You are expected to arrive 10-15 minutes before your appointment time, or earlier if there is paperwork to fill out or information to update with the front desk. If you are unable to make your appointment time, after 15 minutes past the scheduled time, we reserve the right to mark that visit as a no-show, as you may have run past your allotted appointment slot. This will count as a missed appointment, per above.

(Initial) _____ **Forms:** There is a $35 (thirty-five dollar) charge for the completion of FMLA, disability paperwork, and other forms. Since insurance companies do not cover this service, this charge is your responsibility. Payment is due at the time of request. Forms may not be dropped off for completion without prior payment.

(Initial) _____ **Authorization to Retrieve Medication Records:** I authorize Sea Base Medicine to retrieve my complete medication profile from my insurance, pharmacy, or other third party source. I understand this information will be kept confidential and used only to aid in my ongoing treatment. The duration of this authorization is indefinite and continues until revoked in writing.

(Initial) _____ **Controlled Medication Contract:** Starting July 2024, we will require a contract to be signed in order to continue to refill any controlled medications. The details of this contract will be discussed at the time of signing. We require regular visits, monthly unless stated otherwise, to continue to fill controlled medications, and reserve the right to subject you to a random urine or serum drug screening to remain compliant with the Drug Enforcement Agency (DEA).

I have read all of the above and agree to these terms.

_____ _____/_____/_____
Patient's Full Name (Printed) Date of Birth

_____ _____
Signature of Patient or Legal Guardian (if minor) Date

Sea Base Medicine

FINANCIAL POLICIES

Please read, initial, and sign below as indicated.

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(Initial) _____ **Insurance Coverage:** We participate in most insurance plans. Please bring your up-to-date insurance card with you to each visit. It is your responsibility to make sure that our providers are on your specific plan and in-network for you. If you are insured by a plan we accept, but do not have an up-to-date insurance card, payment in full is required until we can verify your insurance coverage. If you are not insured by a plan we do business with, payment is required in full at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

(Initial) _____ **Proof of Insurance:** We must obtain a copy of your driver's license or government ID and a current valid insurance card to provide proof of insurance. If your health insurance changes, it is your responsibility to notify us before your next visit so we can make the appropriate changes to help you maximize your benefits. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the full balance of the claim.

(Initial) _____ **Copayments, Coinsurance and Deductibles:** All copayments, coinsurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments, coinsurance and deductibles from patients can be considered fraud. Please be aware that your insurance company may require a second copy if you address additional problems during a physical exam or at the same time you have a procedure scheduled. We accept cash, check, Visa, Mastercard and Discover.

(Initial) _____ **Claim Submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies a claim for any reason, our office cannot be responsible for that bill. It is your responsibility as the patient to pay the denied amounts in full. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. It is your responsibility to know if your providers are in-network for your insurance plan and what your specific insurance plan's benefits are.

(Initial) _____ **Non-covered Services:** Please be aware that some (and perhaps all) of the services you receive may be non-covered or not considered reasonable or necessary by Medicare and/or other insurance plans. As with all non-covered services, you will be expected to pay in full whatever the insurance companies do not reimburse.

(Initial) _____ **Nonpayment:** If your account is over 90 days past due, you will receive a letter stating that the balance should be paid in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. Should this occur, you will be notified by certified mail and will have 30 days to find a new physician.

I have read all of the above and agree to these terms.

_____ _____/_____/_____

Patient's Full Name (Printed) Date of Birth

_____ _____

Signature of Patient or Legal Guardian (if minor) Date

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PATIENT PREFERENCE REGARDING COMMUNICATION OF HEALTH INFORMATION

Please initial the following if you would like to give us permission to leave a **detailed voice message** regarding **normal** labs or imaging results on your **personal phone number**. Please note that any abnormal results in labs or images that need to be followed up on will **not** be left over voice message. Our policy is to leave 3 voice messages requesting a call back to discuss results, and on the third attempt, we will send out your results via mail.

(Initial) _____ **Detailed Voice Message:** I give permission to Sea Base Medicine to leave a detailed voicemail on the following phone number: _____ regarding **normal** lab values and imaging results.

I hereby give my permission to Sea Base Medicine to disclose and discuss information related to my medical condition(s) to/with the following persons:

Name: _____ Relationship: _____

Phone Number: _____ Okay to leave voicemail? ☐ YES ☐ NO

Name: _____ Relationship: _____

Phone Number: _____ Okay to leave voicemail? ☐ YES ☐ NO

Name: _____ Relationship: _____

Phone Number: _____ Okay to leave voicemail? ☐ YES ☐ NO

☐ I do not wish to give consent for any person to have access to any information regarding my medical condition(s).

This authorization shall remain in effect unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to disclosure of any records.

_____ _____/_____/_____
Patient's Full Name (Printed) Date of Birth

_____ _____
Signature of Patient or Legal Guardian (if minor) Date

Sea Base Medicine

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____/_____/_____

I, the undersigned, authorize the release of, or request access to, the information specified below, for the medical record(s) of the above named patient.

PATIENT INFORMATION IS NEEDED FOR: Continuing medical care

INFORMATION TO BE RELEASED OR ACCESSED: ☐ **ALL HEALTH INFORMATION**

If you would only like specific information released, please check all that apply:

☐ HISTORY & PHYSICAL	☐ PATHOLOGY REPORTS	☐ CONSULTATION REPORTS
☐ PROGRESS NOTES	☐ IMAGING REPORTS	☐ DISCHARGE SUMMARIES
☐ OPERATIVE REPORTS	☐ EMERGENCY ROOM RECORDS	☐ FACE SHEET
☐ LABORATORY REPORTS	☐ HOSPITAL RECORDS	☐ OTHER: _____

TO:

Sea Base Medicine — (817) 953-3420
(Doctor, Hospital, Attorney, Insurance Company, Self, etc) — Phone Number

1631 Lancaster Dr. Ste 300, Grapevine, TX 76051 — (817) 953-3418
Address (Street, City, State and ZIP) — Fax Number

FROM:

_____
(Doctor, Hospital, Attorney, Insurance Company, Self, etc) — Phone Number

_____
Address (Street, City, State and ZIP) — Fax Number

(Initial) _ I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to: history, diagnoses, and/or treatment of drug and alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

_____ _____/_____/_____
Patient's Full Name (Printed) / Legally Authorized Representative — Date of Birth

_____ _____
Signature of Patient or Legally Authorized Representative — Date