Primary Care Internal Medicine, P.L.L.C.
Mark Doerner, M.D., Ph.D.

PATIENT REGISTRATION

Personal Information

Patient Name: _____ Date of Birth: _____ Age: _____

Home Address: _____
Street City State Zip Code

Social Security #: _____ Home Phone: _____ Cell Phone: _____

Sex: ❑ Male ❑ Female Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Employer: _____ Work Phone #: _____ Occupation: _____

Insurance Information (if you have an insurance card, you do not need to complete this section)

1. Primary Insurance Information:

Insurance Name: _____ Policy #: _____ Group #: _____

Policyholder's Name: _____ Policyholder's Date of Birth: _____

Policyholder's S.S.# _____ Policyholder's Place of Employment: _____

Policyholder's Home Address: _____ Policyholder's Home Phone #: _____
Street City State Zip Code

2. Secondary Insurance Information:

Insurance Name: _____ Policy #: _____ Group #: _____

Policyholder's Name: _____ Policyholder's Date of Birth: _____

Policyholder's S.S.# _____ Policyholder's Place of Employment: _____

Policyholder's Home Address: _____ Policyholder's Home Phone #: _____
Street City State Zip Code

In an Emergency notify

Contact Name: _____ Relationship to You: _____

Daytime Phone #: _____ Evening Phone #: _____

Address: _____
Street City State Zip Code

Treatment and Payment Agreement

I authorize examination and treatment for this and all following physician visits.
I authorize release of any medical information necessary to process any insurance billings.
I authorize payment and assignment of insurance benefits to Primary Care Internal Medicine, PLLC.
I understand I am financially responsible for all charges and deductibles not covered by my insurance.
I am personally responsible for supplying accurate and current insurance information.
I authorize a photocopy of this statement to serve as an original.

_____ _____
Patient Signature (Parent or Guardian if patient is under age 18) Date

Confidential Medical History *(2 pages)*
Please complete and bring completed form to your appointment.
Primary Care Internal Medicine, PLLC – Mark Doerner, M.D.

Name _____ Today's Date _____
Age _____ Birthdate _____ Date of last physical exam _____
Occupation: _____

Drug Allergies _____
If you have drug allergies, what reaction do you have to the drug? _____
_____

Medications you take (including over-the-counter medicines and vitamins)

	Medicine Name and Strength?	How much do you take and when?
1.		
2.		
3.		
4.		

(if you need additional space, please use the back)

What medical illnesses do you have? (for example, heartburn, seasonal allergies, high blood pressure, diabetes, heart disease, arthritis, migraines, psychiatric illnesses)

	Medical Illness	When was it first diagnosed (approximate year)?
1.		
2.		
3.		
4.		

(if you need additional space, please use the back)

What surgeries have you had?

	Surgery	Year (approximate) of surgery
1.		
2.		
3.		

(if you need additional space, please use the back)

Women: Date of last period _____ number of pregnancies _____
Contraceptive method _____

Social Habits: Check and describe all that apply
❒ tobacco _____ ❒ sexually active _____
❒ alcohol _____ ❒ special diet _____
❒ exercise _____ ❒ drugs _____

Family History:

	Living?	Age/Age at death	Describe any health problems/Cause of death
Father			
Mother			
Brothers/Sisters			

Please list any family illnesses _____

Health Maintenance: Please indicate the year you last had the following (if not done, leave blank):
Cholesterol checked _____ PSA checked (men) _____ Eye exam _____
Mammogram _____ PAP smear (women) _____ Dental exam _____
Colonoscopy or Flex Sig _____ Bone density _____ TB skin test _____

Immunizations:
Tetanus shot _____ Flu vaccine _____ Pneumonia vaccine _____
Shingles vaccine (Zostavax) _____ Hepatitis A vaccine _____ Hepatitis B vaccine _____
Other _____

Review of Systems

Name _____

Please check Symptoms you currently have or suffer from on a chronic basis:

✓	**GENERAL**	✓	**GASTROINTESTINAL**	✓	**NEUROLOGICAL**
	Fevers/chills		Constipation		Headaches
	Fatigue		Diarrhea		Focal weakness
	Loss or gain of weight		Stomach pain		Focal numbness
	Heat or cold intolerance		Bloating		Seizures
	Difficulty sleeping		Excessive gas		Fainting
	Night sweats		Poor appetite		Dizziness
	Poor concentration		Hemorrhoids		
			Indigestion	✓	**WOMEN ONLY**
✓	**JOINT/MUSCLE/BONE**		Nausea/Vomiting		Abnormal pap smear
	Pain, weakness, numbness in:		Black/Bloody stools		Breast lump
	Arms/Hands		Bowel changes		Breast pain
	Legs/Feet		Excessive thirst		Nipple discharge
	Back/Hips				Bleeding between periods
	Neck/Shoulders	✓	**CARDIOVASCULAR**		Premenstrual symptoms
			Chest pain or chest discomfort		Menstrual pain
✓	**SKIN**		High blood pressure		Vaginal discharge
	Itching/dryness		Irregular heart beat		Vaginal itching
	Changes in moles		Palpitations		Problems with sex life
	New moles		Exercise intolerance		Hot flashes
	Rash		Swelling of ankles		
	Hives		Poor circulation	✓	**MEN ONLY**
	Bruise easily		Varicose veins		Urinary dribbling
	Nail changes				Frequent urination
		✓	**PULMONARY**		Urination at night
✓	**EYE/EAR/NOSE/THROAT**		Shortness of breath		Weak urinary flow
	Vision disturbances		Wheezing		Difficulty starting urine flow
	Loss of hearing		Persistent cough		Lump in testicles
	Dental problems		Cough up blood		Problems with sex life
	Sinus problems				Penis discharge
	Earache	✓	**URINARY**		Sore on penis
	Ear drainage		Blood in urine		Chest wall lumps
	Hay fever/seasonal allergies		Frequent urination		
	Difficulty swallowing		Lack of bladder control	✓	**OTHER**
	Hoarseness		Painful urination		
	Nosebleeds		Frequent urinary tract infections		
	Bleeding gums				
	Snoring	✓	**PSYCHIATRIC**		
	Dry eyes		Depression		
	Dry mouth		Anxiety/nervousness		
			Memory impairment		

This box to be completed by physician

ROS Reviewed: _____ Date Reviewed: _____

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Release of Information (HIPAA)

My Protected Health Information (including lab, x-ray, and diagnostic reports, and appointment reminders) may be released to me in the following ways (***place a check mark next to those you approve***):

❑ All of those listed below.

- Discussed directly with me over the phone at the following phone number(s): _____
  _____
- Mailed to my home address: _____
- Left on my home voice mail at the following number: _____
- Left on my office voice mail at the following number: _____

~ or ~

❑ Only those I have checked below

☐ Discussed directly with me over the phone at the following phone number(s): _____

☐ Mailed to my home address: _____
☐ Left on my home voice mail at the following number: _____
☐ Left on my office voice mail at the following number: _____

I authorize the release of my Protected Health Information to the following people:

Name	**Phone #**	**Relationship**

I understand that I have the right to request restrictions as to how my medical records may be used or disclosed.

I understand that I may make changes regarding the disclosure of my health information at any time, and that I need to notify the physician in writing of these changes.

I understand that my physician maintains my medical records in his office as part of my continuing healthcare, and that the information contained therein may be released to my other physicians and healthcare providers for the purposes of providing my healthcare.

I have received a copy of Primary Care Internal Medicine, P.L.L.C.'s Notice of Privacy Practices for review. Upon my request, I am entitled to receive a copy of the notice.

_____	_____	_____
Printed Name	Patient Signature	Date

Primary Care Internal Medicine, P.L.L.C.

Mark Doerner, M.D.

1111 Raintree Circle, Suite 240
Allen, TX 75013
Tel (972) 908-3455
Fax (972) 908-3477

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please Print):

Name: _____ Date of Birth: _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

RELEASE MY MEDICAL RECORDS FROM:

Name: _____

Tel: _____

Fax: _____

TO:

Mark Doerner, M.D.
Primary Care Internal Medicine, P.L.L.C.
1111 Raintree Circle, Suite 240
Allen, Texas 75013

Phone: 972-908-3455
Fax: 972-908-3477

Please send medical records no later than: _____

Please release a copy of all my medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient: _____ Date: _____
Signature

PHARMACY INFORMATION

We now have electronic prescribing. Please complete the form below with your pharmacy information so that we may send your prescriptions electronically. If you use more than one pharmacy, such as a local pharmacy and a mail-order pharmacy, please list both pharmacies.

Patient Name: _____

Date of Birth: _____

1) Pharmacy Name _____

   Pharmacy Location _____
   Street City State

   Pharmacy Phone Number _____

2) Pharmacy Name _____

   Pharmacy Location _____
   Street City State

   Pharmacy Phone Number _____