Medical City
Family Medicine | Arlington

Welcome to Medical City Family Medicine! We look forward to caring for you as a new patient.

Office Location: 4927 Lake Ridge Parkway, Suite 100 Grand Prairie TX 75052
Phone: 469-506-1671

★ Arrive **30 minutes** prior to your appointment time to allow time for the office to input your information. If not, your appointment may be rescheduled. Please call our office (469)-506-1671 if you will be late.

What to Bring to your visit:

- All forms Completed
- Valid Picture ID
- Current Insurance Cards (if applicable)
- Co-pay. Our office accepts cash and credit /debit cards. If you do not have insurance coverage and are self-pay, the initial visit is based on level of care and can range from $135.90 - 258.00. Co-Pays or payments are DUE AT TIME OF SERVICE.
- Completed Medication list attached.

For those filing on Insurance:

If you have an HMO or Managed Medicaid or Medicare plan, make sure your PCP is listed correctly before your appointment. (See enclosed form to change PCP). If you are unsure what provider to choose, please call our office for instruction.

*****If the insurance does not verify correctly your appointment may be rescheduled. (______) please initial**

Medical City Residency Program

Medical City Family Medicine is part of HCA's Graduate Medical Education Program. The physicians here are in Family Medicine Residency for three years, and are supervised by Board Certified Family Medicine Physicians. Your first visit will be with your assigned Resident and the Supervising physician, so appointments can typically take up to an hour. Please allow time for transportation. If you have any additional questions about the Residency program, you can ask the front desk for more information.

Appointment Details:

*****Each Resident Provider rotates in this office one half-day a week ONLY. (______) please initial**
Appointments will always be on: ______________________________ to ensure continuity of care & your assigned Resident provider is: ___________________________________. If you require acute care, you can see a different provider on a different day. Because of our provider's limited schedule, Non-emergent messages for medication refills, completion of documents, results review, etc…may take up to 72 hours before answering.

*****Should you have any questions, need to cancel or re-schedule your appointment please call our office at least 48-hours in advance at 469-506-1671*****

Office Hours: Monday-Friday 8am-5pm; Closed Daily for Lunch from 12pm-1pm

Patient signature: ____ **Date:** ______________________

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Patient name: ______________________________ **Date of birth:** _________________________

Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, MEDICAL CITY FAMILY MEDICINE may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge MEDICAL CITY FAMILY MEDICINE may use the services of a third-party business associate or affiliated entity as an extended business office (“EBO Servicer”) for medical account billing and servicing.

Assignment of Benefits. I hereby assign to MEDICAL CITY FAMILY MEDICINE any insurance or other third-party benefits available for health care services provided to me. I understand MEDICAL CITY FAMILY MEDICINE has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to MEDICAL CITY FAMILY MEDICINE, I agree to forward all health insurance or third party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII (“Medicare”) or Title XIX (“Medicaid”) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to MEDICAL CITY FAMILY by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for MEDICAL CITY FAMILY MEDICINE, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that MEDICAL CITY FAMILY MEDICINE or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or MEDICAL CITY FAMILY MEDICINE or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: _______________________________ **Date:** _________________

If you are not the patient, please identify your relationship to the patient. Circle of mark relationship(s) from list below:

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify) _______________________________

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APPOINTMENT / MEDICATION / PRESCRIPTION POLICY AND AGREEMENT

Printed Name: ________________________________ DOB _____________________

Appointments: Please make your appointment as scheduled or notify our office within 48 hours prior to rescheduling. Our system will automatically call/leave a message if no answer or text message the number on file to confirm your appointment. If you haven't been receiving the auto reminders, please let the front office verify your contact information. You will receive a written warning on the 2nd occurrence of a NO SHOW/SAME DAY CANCELLATION and a final letter discharging you from the practice on the third occurrence with 30 days to find a new provider. We apologize for the inconvenience, but our physicians are here one half day a week and we have to keep their schedules booked. We offer telemedicine appointments through our HEALOW application and patient portal.

Refills: If you need a refill on your medication, we ask that you call **your pharmacy** and tell them which medication you need refilled. They, in turn, will fax or call us with all the information we need to refill the medication. **If you call us, we will ask you to call your pharmacy.**

We do not refill medications after business hours or on weekends. Our providers do not have access to your medical records after business hours. Please make sure you contact your pharmacy **at least 3 days before you run out of the medication** to allow time for the refill to be processed – refills requests are allowed up to 72 hours for processing once received. Any calls for medications received after 3:30 PM will not be put in until the following business day. A recent office visit may be necessary before any refills are given. We cannot prescribe medications for conditions that have not been addressed in the clinic. We typically have same day availability for acute/minor illnesses.

AFTER BUSINESS HOURS, WEEKENDS AND HOLIDAYS

Our normal business hours are 8 AM to 12 PM and 1 PM to 5 PM, Monday through Friday. We are closed on major US holidays. In case of an emergency, a life-threatening situation, or concerning symptoms, call 911 or go to the nearest emergency room.

Our providers do not have access to your medical records after business hours, weekends, or major holidays. If you would like to schedule a routine appointment, please call during business hours.

By signing below, you agree to the Medical City Family Medicine Policy.

Patient Signature: ____

Date: _____________________

Depression Screening Form

Patient Name: ______________________________ **D.O.B.:** ______________ **Today's Date:** ______________________________

1.) Little interest or pleasure in doing things	O Yes	O No
2.) Feeling down, depressed, or hopeless?	O Yes	O No

If you have answered **yes** to any of these questions, please proceed to the questions listed below.

	Not at all 0	Several Days 1	More than half the days 2	Nearly every day 3
1.) Little interest or pleasure in doing things	[ ]	[ ]	[ ]	[ ]
2.) Feeling down, depressed or hopeless	[ ]	[ ]	[ ]	[ ]
3.) Trouble falling or staying asleep, or sleeping too much	[ ]	[ ]	[ ]	[ ]
4.) Feeling tired or having little energy	[ ]	[ ]	[ ]	[ ]
5.) Poor appetite or overeating	[ ]	[ ]	[ ]	[ ]
6.) Feeling bad about yourself or that you are a failure or have let yourself or your family down	[ ]	[ ]	[ ]	[ ]
7.) Trouble concentrating on things, such as reading the newspaper or watching television	[ ]	[ ]	[ ]	[ ]
8.) Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	[ ]	[ ]	[ ]	[ ]
9.) Thoughts that you would be better off dead, or of hurting yourself in some way	[ ]	[ ]	[ ]	[ ]
Total Score To Be Completed By Office Staff. TOTAL				

If you are 65 or Older, Complete this form

Fall Risk Assessment age 65 and older

Please Note: This screening is required by federal mandate to be completed annually.

Patient Name: ___________________________D.O.B.________________ Today's Date:________________

Increased Fall Risk Factors (check all that apply):

- ___ Diagnoses (Do you have 3 or more existing Medical Conditions?)
- ___ Do you have a prior history of falls within 3 months?
- ___ Incontinence (Do you have an uncontrolled bladder?)
- ___ Visual Impairment (Do you have trouble seeing?)
- ___ Impaired functional mobility (Do you use a cane or walker?)
- ___ Environmental Hazard (Do you have stairs or loose rugs at home?)
- ___ Polypharmacy (Do you take more than 3 medications?)
- ___ Pain affecting level of function (Does pain keep you from performing your daily activities?)
- ___ None of the above

History of falls in the past year? YES NO

If yes how many?: _______________

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Name: ______________________________ Date of Birth:___________________ Age: _________

Current Medications ❐ No Current Medications

***** Medication/Equipment List- Only Include Current Medications/Vitamins/Medical Equipment etc.**

Name	Strength	Dosage	30 or 90 Day Supply	Last Prescribing Physician/Hospital	Need Refill Yes / No

*****We DO NOT prescribe controlled medications. If you require those, we will refer you to a specialist.**

List of Medication we cannot prescribe:

Pain Medication:
Hydrocodone/Acetaminophen (Norco, Lortab, Vicodin, Lorcet etc.)
Oxycodone (OxyCotin, Oxaydo)
Tramadol (Ultracet, Ultram)
Fentanyl (Duragesic Abstral)
Meperidine (Demerol)
Hydrocodone (Zohydro ER, Hysingla)
Lidoderm/Xylocaine (Lidocaine Patch)
Methadone (Dolophine, Methadose)
Codeine
Morphine
Lyrica (Pregabalin)

Others:
Adderall/Add/ADHD Medications
Xenical/Contrace/Phentermine
Soma (Carisporodo) /Muscle Relaxers
Zolpidem (Ambien)/Sleep Medications
Testosterone (ALL FORMS)

Anxiety/Depression:
Alprazolam (Xanax)
Ativan
Lorazepam
Clonazepam (Klonopin)
Diazepam
Temazepam (Restoril)

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Medical History

Patient Name: ________________________________ Date of Birth:________________________Age:____

Reason For Visit: ________________________________ Date of Last Visit w/PCP:________________

Preferred Imaging Center: Medical City Arlington Envision Touchstone No Preference

Preferred Pharmacy: ________________________________ **Phone# / City:**________________________

Mail Order Pharmacy:_____________________________**Phone# / Fax#**:___________________________

Preferred Lab: Medical City Arlington Lab Corp Quest Clinical Pathology No Preference

Medical History (Please check all that apply)

□ Allergies	□ Enlarged Prostate	□ Incontinence
□ Anemia	□ Frequent Falls/Balance Issue	□ Kidney (Renal) Disease
□ Anxiety	□ Gall Stone	□ Kidney Stones
□ Arthritis	□ GERD/Acid Reflux	□ Shortness of Breath
□ Asthma	□ Heart Disease	□ Skin Condition
□ Blood Clots	□ Hearing Loss	□ STD Type:
□ Cancer Type:	□ Hepatitis Type:	□ Stroke
□ Diabetes Type:	□ High Blood Pressure	□ Thyroid Disease
□ Depression	□ High Cholesterol	□ Vision Loss
□ Emphysema/COPD	□ Irritable Bowel Syndrome	□ Other:

❒ Pregnant ❒ Breast Feeding Date of last Menstrual Cycle ______________ # of Births:________

Allergies

❒ No Known Allergies

Medication/Food: _________________________ Reaction: ___________________________________❒ Critical

Medication/Food: _________________________ Reaction: ___________________________________❒ Critical

Other Allergy: ____________________________ Reaction: ___________________________________❒ Critical

Past Surgeries/Hospitalizations

❒ No Surgeries ❒ No Hospital Stays

Year:__________Procedure/Reason:____________________________________Facility:________________

Year:__________Procedure/Reason:____________________________________Facility:________________

Year:__________Procedure/Reason:____________________________________Facility:________________

List any Specialist(s) you are currently seeing so we can obtain records and send updated referrals:

PREVIOUS PRIMARY CARE PROVIDER NAME: _____________________________

PH#: _____________________________ **FAX#:**______________________________

SPECIALISTS PROVIDER NAME(S):

Dr:______________________________ Phone:______________________________ Reason:________________________

Dr:_____________________________ Phone:______________________________ Reason:________________________

Dr:_____________________________ Phone:______________________________ Reason:________________________

Medical History- *Continued*

Name: ________________________________ Date of Birth:____________________ Age: __________

Family Medical History ❒ No Significant Family History Known

Member	Status/ Age	Health Conditions	Cause of Death/AOD
Mother	❒ Alive ❒ Deceased ❒Unknown AGE:		
Father	❒ Alive ❒ Deceased ❒Unknown AGE:		
Brother	❒ Alive ❒ Deceased ❒Unknown AGE:		
Sister	❒ Alive ❒ Deceased ❒Unknown AGE:		
Daughter	❒ Alive ❒ Deceased ❒Unknown AGE:		
Son	❒ Alive ❒ Deceased ❒Unknown AGE:		

Social History

Alcohol Use: ❒ Never ❒ Former ❒ Occasional ❒ Moderate ❒ Frequently Type: Beer Wine Liquor

Smoker: ❒ No ❒ Former-Years Smoked:_____ ❒ Current (Age Started ______) Packs per day______

Other Tobacco: ❒ Never ❒ Former-Years Used _______ ❒ Current (Age Started _____) Cans per day _________

Illicit/Recreational Drug Usage: ❒ Never ❒ Prior ❒ Current/Usage/Type:_______________________________

Caffeine: ❒ None ❒ Occasional ❒ Moderate # Per Day:________ ❒ Tea/Coffee ❒ Soda ❒ Energy Drinks

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Partner ❒ Widow

Sexually Active: ❒ Yes ❒ No Type of Contraception:________________ ❒ Multiple Partners ❒ STD Suspicion

If you have any Personal Safety Concerns, List: ____

Diet: ❒ Regular ❒ Vegan ❒ Vegetarian Exercise: ❒ None ❒ Occasional ❒ Moderate ❒ Heavy

Occupation: ❒ Student ❒ Full-Time ❒ Part-time ❒ Homemaker ❒ Retired ❒ Disabled ❒ Not-Employed

Stress Level: ❒ Low ❒ Moderate ❒ High What are your stressors? __________________________________

Health Screenings

Lab work	Date	Facility	Abnormal? Y N
Pap smear	Date	Facility	Abnormal? Y N
Mammogram	Date	Facility	Abnormal? Y N
Colonoscopy	Date	Facility	Abnormal? Y N
Bone Density	Date	Facility	Abnormal? Y N
Lung Cancer Screen	Date	Facility	Abnormal? Y N

Vaccinations

Influenza	Date	Shingles	Date
Covid-19	Date	Tetanus	Date
Pneumococcal	Date	Other:	Date