ALVA FAMILY PRACTICE

6908 BOOT RANCH RD
ODESSA,TEXAS 79765
PHONE: (432) 530-7345 or (432) 312-2491
FAX: (432) 400-1415

DATE: _____ **New DPC Member ( ) Yes ( ) No**

PATIENT DEMOGRAPHICS

FULL NAME: _____ DATE OF BIRTH: _____

GENDER: ☐ FEMALE ☐ MALE DO YOU HAVE AN ADVANCED DIRECTIVE (LIVING WILL)? ☐ YES ☐ NO

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMAIL: _____

PRIMARY PHONE: _____ ☐ Home ☐ Mobile ☐ work ☐ Other

Drivers License # _____ State: _____

***** Need to send a copy/picture of your insurance card (front and back) *****

INSURANCE NAME: _____ SUBSCRIBER ID: _____ GROUP: _____

SOCIAL SECURITY #: _____ REFERRED BY: _____

NEXT OF KIN (FOR EMERGENCY): _____

RELATION: _____ PHONE: _____

LIST ANY CURRENT MEDICAL ROBLEMS OR CHRONIC ILLNESSES

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____

9. _____ 10. _____

LIST ANY PHYSICIANS AND/OR PRACTIONERS YOU CURRENTLY SEE

NAME: _____ SPECIALTY: _____

NAME: _____ SPECIALTY: _____

NAME: _____ SPECIALTY: _____

LIST ANY MEDICATION THAT YOU CURRENTLY TAKE, INCLUDING OVER-THE-COUNTER

NAME	STRENGTH	DIRECTION	PRESCRIBED BY

LIST ANY ALLERGIES TO MEDICATION, X-RAY DYES OR FOOD

1._____ 3._____

2._____ 4._____

LIST ANY PAST SURGERIES OR HOSPITALIZARTIONS

1._____ YEAR: _____ 4._____ YEAR: _____

2._____ YEAR: _____ 5._____ YEAR: _____

3._____ YEAR:_____ 6._____ YEAR:_____

LIST NAY CHILDHOOD ILLNESS

1._____ 3._____

2._____ 4._____

LIST HEALTH PROBLEMS AND CAUSES OF DEATH IF APPLICABLE

	LIVING/DECEASED	AGE	MEDICAL PROBLEMS
FATHER:			
MOTHER:			
BROTHER(S):			
SISTER(S):			
MATERNAL FATHER:			
MATERNAL MOTHER:			
PATERNAL FATHER:			
PATERNAL MOTHER:			

RECORD THE LAST YEAR YOU HAD THE FOLLOWING, PUT N/A IF NOT DONE.

COLONOSCOPY: _____ YEAR: _____ FLU VACCINE: _____ YEAR: _____

MAMMOGRAM: _____ YEAR: _____ TETANUS: _____ YEAR: _____

PAP SMEAR: _____ YEAR: _____ PNEUMONIA: _____ YEAR: _____

BONE DENSITY: _____ YEAR: _____ COVID: _____ YEAR: _____

PROSTATE EXAM: _____ YEAR: _____ OTHER: _____

SOCIAL HISTORY

CONSUME ALCOHOL? ☐ YES ☐ NO AMOUNT: DAILY ____ WEEKLY: ____ MONTHLY:____ SOCIAL: _____

SMOKING: ☐ YES ☐ NO CURRENT: ____ FORMER: _____ AMOUNT: _____

EXERCISE: ☐ YES ☐ NO OFTEN: _____ CARDIO: _____ WEIGHTS: _____

MARITAL STATUS: MARRIED: ☐ SINGLE: ☐ DIVORCED: ☐ WIDOWED: ☐ OTHER: ☐ _____

OCCUPATION: _____ COMPANY: _____

PHARMACY: _____

Reason for visit: _____

GAD - 7

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1 Feeling nervous, anxious or on edge?	0	1	2	3
2 Not being able to stop or control worrying?	0	1	2	3
3 Worrying too much about different things?	0	1	2	3
4 Trouble sleeping?	0	1	2	3
5 Being so restless that it is hard to sit still?	0	1	2	3
6 Becoming easily annoyed or irritable?	0	1	2	3
7 Feeling afraid as if something awful might happen?	0	1	2	3
ADD COLUMNS				
TOTAL				

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1 Little interest or pleasure in doing things?	0	1	2	3
2 Feeling down, depressed or hopeless	0	1	2	3
3 Trouble falling or staying asleep or sleeping too much?	0	1	2	3
4 Feeling tired or having little energy?	0	1	2	3
5 Poor appetite or overeating?	0	1	2	3
6 Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7 Trouble concentrating on things, such as reading the newspaper or watching television?	0	1	2	3
8 Moving or speaking so slowly / fast that other people could have noticed. Being so fidgety or restless that you have been moving around a lot more than usual?	0	1	2	3
9 Thoughts that you would be better off dead or of hurting yourself?	0	1	2	3
ADD COLUMNS				
TOTAL				

ALVA
FAMILY PRACTICE

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Cardholder Name: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other: _____
Cardholder Name (as shown on card): _____
Card Number: _____ CVV: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize Alva Family Practice to charge my credit card above for agreed upon purchases and automatic fees such as memberships, ect. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date

ALVA

FAMILY PRACTICE

No Show Policy

We schedule our appointments so that each patient receives the right amount of time to be seen by our staff. That's why it is very important that you keep your scheduled appointment with us and arrive on time.

As a courtesy and to help patients remember their scheduled appointments, Alva Family Practice sends text messages and email reminders in advance of the appointment time.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least a 24 hour notice.

If you do not cancel or reschedule your appointment with at least 24 hour notice, we may assess a $ 25.00 "No Show" service charge to your account. After the second no show you will be charged a $50.00 fee.

After three consecutive "No Shows" to your appointment our practice may decide to terminate its relationship with you.

I understand the "No Show" policy of Alva Family Practice and **agree to provide a credit card to keep on file,** which may be charged $25.00 or $50.00 for any no show of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 24 hours in advance in order to avoid a potential no show charge to the credit card provided.

_____ **I understand that as a new patient coming in for my first appointment, I will still be accounted for paying the "No Show Fee" if I do not call in advance.**

____ **I understand that I will get charged a $100.00 non-refundable fee at the time of making my initial appointment.**

Patient Signature: _____

Print Patient Signature: _____

Date: _____

ALVA
FAMILY PRACTICE
Phone: 432-312-2491 Fax- 432-400-1415

Medical Release Form

Patient Name: _____

D.O.B_____ SSN: _____

Address: _____ City: _____

State: _____ Zip: _____

Phone: _____ Email: _____

Information Requested From

Name: _____

Address: _____ City: _____

State: _____ Zip: _____

Phone: _____ Fax: _____

Send Information To

Name: Alva Family Practice Address: 6908 Boot Ranch Rd Odessa Tx 79765
Phone Number: 432-312-2491 Fax: 4324001415

I, _____, hereby grant permission for you to release confidential health information about me, by releasing a copy of my medical record pr a summary or narrative of my protected health information, to the physician/ person/ facility above.

_____

Signature

_____

Date

ALVA
FAMILY PRACTICE

Medical Information Release Form
(HIPPA Release Form)

Name: _____ Date of Birth: _____

Release of Information

( ) I authorize the release of information including the diagnoses, records, examination rendered to me and claims information. This Information may be released to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

( ) Information is NOT to be relased to anyone.

This release of Information will remain in effect until terminated by me in writing.

Messages

Please call: ( ) my cell ( ) my work ( ) text

If unable to reach me: ( ) you may leave a detailed message

( ) leave a message asking to return your call

Signed:_____ Date:_____