# 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** | | | | |

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# 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

biote

# FEMALE HEALTH ASSESSMENT QUESTIONNAIRE

NAME: _____ EMAIL: _____

TODAY'S DATE: _____ PHONE: _____

Please mark the appropriate box for each symptom you may be experiencing.

| SYMPTOMS | NONE | MILD | MODERATE | SEVERE | VERY SEVERE |
|---|---|---|---|---|---|
| Physical Exhaustion (fatigue, lack of energy, stamina or motivation) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sleep Problems (difficulty falling asleep or sleeping through the night) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Irritability (mood swings, feeling aggressive, angers easily) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Decline in drive or interest (loss of "zest for life," feeling down or sad) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Difficulties with memory (concentration, finding the right word, or retaining information) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Vaginal dryness or difficulty with sexual intercourse | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sexual Problems (change in desire, activity, orgasm and/or satisfaction) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sweating (night sweats or increased episodes of sweating) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hot Flashes (burst that starts in chest and lasts for short duration) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hair loss, thinning or change in texture of hair | ☐ | ☐ | ☐ | ☐ | ☐ |
| Feeling cold all the time, having cold hands or feet | ☐ | ☐ | ☐ | ☐ | ☐ |
| Headaches or migraines (increase in frequency or intensity) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Weight (difficulty losing weight despite diet/exercise) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bladder problems (difficulty in urinating, increased need to urinate, incontinence) | ☐ | ☐ | ☐ | ☐ | ☐ |

Other symptoms or unique health circumstances to take into consideration:

# BIOTE FEMALE HEALTH HISTORY & SYMPTOMS

## PATIENT INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Weight: _____ Height: _____

## PATIENT QUESTIONS

Currently pregnant or trying to conceive? ☐ Yes ☐ No

Date of last mammogram: _____

Had menstrual cycle (within last 12 months)? ☐ Yes ☐ No

Date of last menstrual cycle: _____

Had endometrial ablation? ☐ Yes ☐ No

Is the patient on birth control? ☐ Yes ☐ No Name of birth control: _____

Has the patient had a hysterectomy? ☐ Yes ☐ No

If so, type of hysterectomy: ☐ Complete (uterus and ovaries removed) ☐ Partial (uterus only removed)

Is the patient currently utilizing BHRT or HRT? ☐ Yes ☐ No

If yes, select types of Hormones: ☐ Testosterone ☐ Progesterone ☐ Estrogen ☐ Thyroid

List Name and Dose of Hormone(s): _____

Is the patient currently on statins? ☐ Yes ☐ No

Is the patient a smoker? ☐ Yes ☐ No

Is the patient currently on oral nitrates? ☐ Yes ☐ No

## MEDICAL HISTORY

**Select all that apply:**

**Cardiovascular Conditions:**

☐ Heart Attack or Stroke (within last 6 months)

☐ DVT or Blood Clot (within last 6 months)

☐ Hypertension

☐ Hyperlipidemia

☐ Obstructive Sleep Apnea

☐ Atrial Fibrillation

☐ Tachycardia

**Gynecological Conditions:**

☐ Pre-Menstrual Syndrome

☐ Endometriosis or History of Endometriosis

☐ Fibrocystic Breast Disease

☐ Fibroids or History of Fibroids

☐ Polyps or History of Endometrial Polyps

**Cancer:**

☐ Breast Cancer or History of Breast Cancer

☐ Endometrial Cancer

☐ Cervical Cancer

☐ Ovarian Cancer

☐ Thyroid Cancer or History of Thyroid Cancer

☐ Meningioma

☐ Except for Basal Cell Carcinoma any Other Cancers?

**Neurological Conditions:**

☐ Epilepsy or Seizure Disorder

☐ Depression/Anxiety

# BIOTE FEMALE HEALTH HISTORY & SYMPTOMS

## MEDICAL HISTORY

**Endocrine and Metabolic:**

- ☐ PCOS
- ☐ Diabetes Type 2 or Insulin Resistance
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Multiple Endocrine Neoplasia Type-2

**Autoimmune Conditions:**

- ☐ Diabetes Type 1
- ☐ Hashimoto's Thyroiditis
- ☐ Graves' Disease
- ☐ Rheumatoid Arthritis
- ☐ Multiple Sclerosis
- ☐ Systemic Lupus (Erthematosus)
- ☐ Psoriasis
- ☐ IBS (Irritable Bowel Syndrome)
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis

**Organ Specific Conditions:**

- ☐ Liver Disease or History of Liver Disease
- ☐ Kidney Disease or History of Kidney Disease
- ☐ LAM (Lymphangioleimyomatosis)
- ☐ Osteoporosis or Osteopenia
- ☐ HIV
- ☐ Hepatitis
- ☐ Hemochromatosis
- ☐ Pancreatitis or History of Pancreatitis
- ☐ History of or Gall Bladder Disease

## SYMPTOMS AND CONCERNS

**Select all that apply:**

- ☐ Hot Flashes
- ☐ Night Sweats
- ☐ Vaginal Dryness
- ☐ Decreased Interest in Sex
- ☐ Inability To or Delayed Orgasm
- ☐ Painful Intercourse
- ☐ Urinary Incontinence
- ☐ Frequent Urinary Tract Infection
- ☐ Breast Tenderness
- ☐ Weight Gain
- ☐ Hair Loss
- ☐ Hair Thinning
- ☐ Thinning Eyebrows
- ☐ Cold Hands or Feet
- ☐ Brittle Nails
- ☐ Dry or Flaking Skin
- ☐ Lack of Energy (Fatigue)
- ☐ Decreased Muscle Mass
- ☐ Acne
- ☐ Facial Hair
- ☐ Dry Eyes
- ☐ Joint Pain
- ☐ Difficulty Sleeping
- ☐ Mind Racing at Bedtime

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# B12 Lipotropic Shot & Super B12 Complex Consent Form

A New You Health and Wellness uses pharmaceutical B12 Lipotropic and B12 Myoden combination, clinically proven to help accelerate metabolism and burn fat. They are used to enhance your current weight loss efforts i.e. following a healthy diet plan, drinking plenty of water and exercising.

## How do B12 Lipotropic injections work?

Lipotropic is a fancy word for three amino acids (methionine, inositol, and choline) essential for the health of your liver. Your liver is the organ responsible for removing fat and toxins from our body, so if it is healthier, it will work better for you. B12 can give you an energy boost, which helps you to burn calories. The amino acids in the B12 Lipotropic shots are compounds that enhance liver function and increase the flow of fats and bile from the liver and gallbladder. By definition, a Lipotropic substance decreases the deposit, or speeds up the removal of fat within the liver. The key amino acids "Lipotropic" used to make these shots:

## B12 Lipotropic injections include: B1, B2, B3, B5, B6, B12, and Vitamin C

**-Vitamin B12 (Hydro cobalamin)** – essential for helping to form new, healthy cells in the body. It also boosts energy, helping increase activity levels.

**-Choline**- supports the health of the liver in its processing and excretion of chemical waste products within the body, Moreover, it is required for the transport and metabolism of the endocrine, cardiovascular and liver systems.

**-Methionine**- an amino acid important for man bodily functions. It acts as a lipotropic agent to prevent excess fat buildup in the liver and the body, is helpful in relieving, or preventing fatigue and may be useful in some cases of allergy because it reduces histamine release.

**-Inositol**- A nutrient belonging to the B vitamin complex, is closely associated with choline. It aids in the metabolism of fats and helps reduce blood cholesterol. Inositol participates in action of serotonin, a neurotransmitter known to control mood and appetite.

## Super B12 Complex Injection Include all of the above plus:

- **Acetyl L-Carnitine-** an amino acid (building block for proteins) that is naturally produced in the body. It helps the body produce energy, carry fatty acids into the cell so they can be burned as fuel and assist in the reduction of belly fat.

## Acknowledgment and Informed Consent

1. The nature and purpose of the injection, possible alternative methods of treatment, risks involved, possible consequences, and the possibility of complications have been explained to me.
2. Each patient responds differently to medicine and may respond differently from on treatment to the next. As with all medicines, results are temporary, and regular dosing is necessary. The length of time the injectable medication lasts varies in each patient. No guarantee can be made with regard to the result or length of time it lasts.
3. I understand that there are some risks with any treatment. The following is the list of possible risks with injection: pain or bruising of the injection site, scarring of the skin (unlikely), and possible skin infection- a possibility any time the skin is broken, even with sterile needles.
4. I have been given the opportunity to have all of my questions answered.

I, _____ have read and understand the ingredients of the injection being administered to me, and I consent to treatment.

_____

Signature

_____

Date

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# 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: _____

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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

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# 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:_____