5407 ANDREWS HWY
ODESSA, TEXAS 79762
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 DIDRECTIVE (LIVING WILL __ YES __ NO

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMAIL: _____

PRIMARY PHONE: _____ ___ Mobile ____Work. ____Other

DRIVERS LICENSE #: _____ STATE: _____

********* NEED TO SEND A COPY / PICTURE OF YOUR INSURANCE CARD (FRONT & BACK) *********

INSURANCE NAME: _____ SUBSCRIBER ID: _____ GROUP #: _____

REFERRED BY: _____ HOW DID YOU HEAR ABOUT US: _____

EMERGENCY CONTACT: _____ RELATION: _____ PHONE #: _____

LIST ANY CURRENT MEDICAL PROBLEMS 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: _____

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LIST ANY MEDICATIONS THAT YOU URRENTLY 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 HOSPITALIZATIONS

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

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

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

LIST ANY 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: _____ MAIL-ORDER PHARMACY: _____

REASON FOR VISIT: _____

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PATIENT HEALTH QUESTIONNAIRE 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. Felling 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, watching television or scrolling on your phone?	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				

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: __ Master Card. __ 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

_____

Print Customer Signature

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 our 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 a 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 pr $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 no call-in advance.

____ I understand that I will get charged a $125.00 non-refundable fee at the time of making my initial appointment.

Patient Signature: _____

Print Patient Signature: _____

Date: _____

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: _____

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

Signature: _____ Date: _____

Send Information To:

Alva Family Practice

5407 Andrews Hwy

Odessa Texas 79762

Phone: 432-312-2491 or 432-530-7345. Fax: 432-400-1415

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 released 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

Patient signature: _____ Date: _____

Healing the Body. Nurturing the Soul. Embracing the Whole Person.

At Alva Family Practice, we believe true healing is more than a prescription or a procedure—it's a sacred journey. Health is not just physical. It's emotional. It's spiritual. And at times, healing must begin from the inside out.

Whether you follow a religion, seek spiritual peace, or simply believe in the power of hope and love—we welcome you with open hearts. Our care is rooted in compassion and guided by the understanding that medicine and faith are not in opposition—they are partners.

"A cheerful heart is good medicine." – Proverbs 17:22

We recognize that every person carries not only physical burdens, but emotional and spiritual wounds. That's why we care for the whole you—your body, your heart, and your inner life.

✨ We respect all faiths, beliefs, and traditions
🕊️ We honor your spiritual path—wherever it leads
🕊️ We invite you, if you wish, to join us in prayer or reflection as part of your healing process

You are never just a number or a chart in our clinic. You are a child of purpose, a human being created with intention, and your life carries deep meaning. Your healing matters—to us, and to something greater.

Faith and Medicine—Working Together

- Scientific medicine treats the body.
- But faith ignites hope.
- Prayer opens hearts.
- Stillness brings clarity.
- Gratitude rewires the mind.
- And sometimes, a whispered prayer is as powerful as any prescription.

Here, you are encouraged to bring your spirituality into your healing journey. Whether it's through quiet reflection, prayer

We Are Here to Walk With You

No matter your background, belief, or story—you are welcome.

- Let us support your healing.
- Let us nourish your soul.
- Let us care for your whole being.

Because when spirit and science walk hand in hand, healing becomes not just possible—but transformational.

🕊️ Healing starts with honesty. Flourishes with faith. And completes with compassion.
🕊️ Come as you are. Leave lighter. Leave whole.

From all the staff at Alva Family Practice,
George Alva, FNP-C