NEW PATIENT HEALTH INFORMATION

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BIMGA
BEAUMONT INTERNAL MEDICINE & GERIATRIC ASSOCIATES

OUR PROVIDERS

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PATIENT INFORMATION

Receive communications & statements electronically? ☐ Yes ☐ No

DOCTOR: _____ TODAY'S DATE: _____

NAME: _____ DATE OF BIRTH: _____

SEX: MALE FEMALE SOCIAL SECURITY #: _____

EMAIL: _____

ADDRESS: _____ CITY / STATE: _____ ZIP: _____

PHONE #: _____ ALTERNATE #: _____

REFERRED BY: _____

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED

EMPLOYER: _____ PHONE: _____

NEAREST RELATIVE: _____ PHONE: _____

RELATIONSHIP: _____

PREVIOUS PRIMARY CARE PHYSICIAN: _____

Have you seen your primary care physician in the last 2 years? YES NO

How often do you see your primary care physician? _____

Reason for changing physicians: _____

Have you ever been discharged from another practice? YES NO

Do you change physicians frequently? YES NO

How many times have you been admitted to the hospital in the last year? _____

What specialists do you see? _____

INSURANCE PHONE #: _____ MEMBER ID #: _____

We will file primary and secondary insurance for you. We do not file a third insurance.

I, the undersigned, certify that I have insurance coverage with _____ insurance company. I understand that I am financially responsible for all charges, whether or not they are paid by insurance. I hereby authorize Beaumont Internal Medicine & Geriatric Associates to release all information necessary to secure the payment of benefits, and I authorize the use of this signature on all insurance submissions. Co-pays, co-insurance, and deductibles are due the day of service. Please review our financial policies for further information.

PRIMARY INSURANCE: _____ ID #: _____ GROUP #: _____

SECONDARY INSURANCE: _____ ID #: _____ GROUP #: _____

_____ _____ _____

Signature of patient or personal representative | Printed name (if personal representative, list relationship) | Date

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MEDICAL HISTORY

Please complete every table below. If a section does not apply, write "NONE."

◆ **PRESENT ILLNESS** — List your primary ailments as of today and how long you have had them.

Current Medical Issue	How Long?

◆ **PAST HISTORY** — List all serious illnesses, injuries, and operations.

Procedure / Illness	Year

◆ **CURRENT MEDICATIONS** — List ALL medications, including vitamins and herbal supplements.

Medication, Vitamin, or Supplement	Dose & Frequency

◆ **ALLERGIES** — List all known drug, food, and environmental allergies.

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REVIEW OF SYSTEMS

PLEASE CIRCLE YES OR NO FOR EACH QUESTION BELOW

EAR, NOSE & THROAT

Do you have any type of eye disease?	YES	NO
Do you have any type of ear disease?	YES	NO
Do you have hay fever or sinus trouble?	YES	NO
Do you have frequent sore throats?	YES	NO

CHEST

Have you ever had a chronic chest condition (such as asthma or bronchitis)?	YES	NO

If yes, specify: _____

Do you smoke?	YES	NO

If yes, packs/day: _____

CARDIOVASCULAR

Has a doctor ever said you had heart trouble?	YES	NO
Has a doctor ever said you have high blood pressure?	YES	NO
Have you ever had rheumatic fever?	YES	NO
Do you tire easily or get short of breath?	YES	NO
Do your ankles swell at times?	YES	NO

GASTROINTESTINAL

Do you suffer from upset stomach?	YES	NO
Has a doctor ever said you had an ulcer?	YES	NO
Do you drink alcoholic beverages?	YES	NO
Do you use recreational drugs?	YES	NO
Have your bowel habits changed in the past year?	YES	NO

GENITOURINARY

Have you ever had kidney disease or infection?	YES	NO
Have you had frequent urinary tract infections?	YES	NO

METABOLIC

Do you have diabetes?	YES	NO
Do you have excessive thirst?	YES	NO
Do you have excessive urine output?	YES	NO
Do you have thyroid trouble?	YES	NO

JOINTS

Are your joints often painful or swollen?	YES	NO

NERVES

Have you ever had a nervous breakdown?	YES	NO
Do you feel tense and nervous all the time?	YES	NO
Have you ever been a patient in a mental health facility?	YES	NO

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FAMILY HISTORY

Please circle the state of health for each person below. If deceased, please give the cause of death.

Relative	State of Health	If Deceased — Cause of Death
Spouse	GOOD FAIR POOR DEC.	
Father	GOOD FAIR POOR DEC.	
Mother	GOOD FAIR POOR DEC.	
Sisters	GOOD FAIR POOR DEC.	
Brothers	GOOD FAIR POOR DEC.	

HAS ANYONE IN YOUR FAMILY HAD ANY OF THE FOLLOWING?

Diabetes	YES	NO	Epilepsy	YES	NO
Tuberculosis (TB)	YES	NO	Severe rheumatism	YES	NO
Heart trouble	YES	NO	Cancer	YES	NO
High blood pressure	YES	NO			

Has anyone in your family ever been a patient in a mental hospital? YES NO

Has anyone in your family ever died by suicide? YES NO

FOR WOMEN ONLY

How many children do you have? _____ **Ages:** _____

Have you ever had a miscarriage? YES NO **Last menstrual period:** _____

Are your periods regular? YES NO **Last pregnancy:** _____

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HEALTH SCREENINGS

PATIENT'S NAME: _____ DOB: _____ DATE: _____

To be completed by the nurse at time of visit

Did you bring a current medication list today? YES NO

Depression screening: Do you have little interest or pleasure in doing things? YES NO

Feeling down, depressed, or hopeless? YES NO

ADVANCED CARE PLANNING — To be completed by the patient prior to the office visit.

Do you have any of the following advanced care plans? Circle all that apply: LIVING WILL MEDICAL POWER OF ATTORNEY DNR

OTHER: _____

Who have you named as your surrogate decision maker? _____ NONE

If you circled any advanced directive above, please make sure your physician has a copy on file.

If you suffered a life-altering event (e.g., a stroke), who best understands the care you would want? _____

Who do you turn to for help when working through a crisis? _____

What kind of personal care would you accept? Circle all that apply:

HOME HEALTH HOSPICE NURSING HOME PRIVATE CARE ASSISTED LIVING SKILLED NURSING ANY MEANS NECESSARY DEPENDS ON CIRCUMSTANCES

Have you been hospitalized in the last year? YES NO

Do you use any assistive devices? Circle all that apply:

NONE CANE WALKER WHEELCHAIR LIFT CHAIR BEDSIDE COMMODE SCOOTER HOSPITAL BED SHOWER CHAIR

Do you require the assistance of another person to travel? YES NO

Are you compliant with taking your medications as directed? (If no, please explain below) YES NO

Are you compliant with keeping your doctor visits? (If no, please explain below) YES NO

VACCINE & OSTEOPOROSIS SCREENING

Influenza (flu): Have you had a flu vaccine for the current season (20__ – 20__)? If no, would you like one today? YES NO

Pneumococcal (age 65+): Have you received Pneumococcal 23, Prevnar 13, or Prevnar 20? (Note dates below.) If no, would you like one today? YES NO

Vaccine dates: _____

Osteoporosis (women): Date of last DEXA scan: _____ **Result:** NORMAL OSTEOPENIA OSTEOPOROSIS UNKNOWN

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HEALTH SCREENINGS (continued)

EYE EXAM SCREENING

Last routine eye exam: _____ Eye care provider: _____

Last diabetic eye exam: _____ Do you have diabetic retinopathy? YES NO UNK

CANCER SCREENING

Last colonoscopy: ____ NEVER Result: NORMAL POLYPS DIVERTICULOSIS DIVERTICULITIS UNKNOWN

Gastroenterologist: _____

Last mammogram (women): _____ Location: _____

Last PSA (men): _____

Cognitive-function exam: the nurse or medical assistant will screen you in the exam room.

PAIN SCREENING

Overall daily pain level (0 = no pain, 10 = worst): _____

When you experience pain, how do you control it? _____

What part of your body causes you pain? _____

Do you take prescribed pain medication? YES NO

Do you have a pain doctor? YES NO

Do you want to discuss your pain today? YES NO

SOCIAL HEALTH SCREENING

Smoking status: NEVER SMOKER CURRENT SMOKER FORMER SMOKER OCCASIONAL SMOKER

How much do you smoke daily? _____

Do you want to quit smoking? YES NO

Do you use smokeless tobacco? YES NO

FALL RISK ASSESSMENT

Falls in the last year:

NO FALLS 1 FALL, NO INJURY 2–5 FALLS, NO INJURY 5+ FALLS, NO INJURY 1 FALL WITH INJURY 2–5 FALLS WITH INJURY 5+ FALLS WITH INJURY

FUNCTIONAL ABILITY — Dementia patients only.

Do you require assistance with any of the following? Circle all that apply:

BATHING DRESSING TOILETING TRANSFERRING CONTINENCE FEEDING MEAL PREP HOUSEWORK FINANCES MEDICATION PHONE USE SHOPPING TRANSPORTATION

GENERAL HEALTH & WELLNESS SCREENING

Any current health concerns you would like to discuss today? _____

GENERAL HEALTH SCREENING

During the past 4 weeks, how would you rate your health? EXCELLENT GOOD FAIR POOR

Which of the following are problems for you? (Check all that apply.)

- ☐ I am tired or fatigued
- ☐ I am lonely or lack support at home
- ☐ I experience a lot of stress or anger
- ☐ I have difficulty taking or remembering my medicines

Do you feel safe in your home?	YES NO	Do you fasten your seatbelt in the car?	YES NO
Any sexual problems you'd like to discuss?	YES NO	Do you have any problems with pain?	YES NO
Do you exercise 20 min, 3+ days per week?	YES NO	Do you follow a specific diet (low sodium/sugar)?	YES NO

FUNCTIONAL STATUS

Can you perform activities of daily living (ADLs) independently — groom, bathe, dress, eat, walk, use the bathroom?	YES NO
Can you perform all instrumental ADLs independently — shopping, cooking, finances, phone, laundry, housework, driving, transportation, medications?	YES NO
Do you have trouble with incontinence (leaking of urine)?	YES NO

RISK SCREENING

Any problems with your vision?	YES NO	Any problems with your hearing?	YES NO
Any problems with your teeth or dentures?	YES NO	Concerned about your memory?	YES NO

OPIOID & ADDITIONAL SCREENINGS

Do you take any opioid medications? YES NO

Ever had a fecal occult blood test? YES NO If yes, when? _____

Ever had a Cologuard screening? YES NO If yes, when? _____

Ever received a Shingrix (shingles) vaccine? YES NO If yes, when? _____

CONSENT & ACKNOWLEDGEMENTS

Please place your initials on each line below.

Prescription History Consent

I fully understand the Prescription History access information provided and stated in this New Patient Packet.

Certified Nurse Practitioner / Certified Physician Assistant

I understand that certain care may be provided by a Certified NP or a Certified PA employed by Beaumont Internal Medicine & Geriatric Associates, as stated in the Nurse Practitioner Consent Form provided.

Authorization to Release Healthcare Information

I acknowledge that I have received and understand the Authorization to Release Healthcare Information Form, and I have authorized the release of my healthcare information to Beaumont Internal Medicine & Geriatric Associates.

Patient Controlled Substances & Pain Management Agreement

I fully understand that the purpose of this agreement is to prevent misunderstandings about certain medicines I will take for pain management, anxiety, and/or sleep disorders, and to help both my doctor and me comply with the law regarding controlled pharmaceuticals.

Authorization to Discuss Medical Information

By completing the Authorization to Discuss Medical Information Form, I authorize the use or disclosure of Protected Health Information (PHI) as required by HIPAA (45 C.F.R. Parts 160 and 164). BIMGA may use or disclose PHI per the Notice of Privacy Practices. This permission is effective from the date of signature forward; I may revoke it in writing at any time. PHI may include records relating to mental healthcare, communicable disease, HIV/AIDS, pregnancy, or treatment for alcohol or drug abuse. My treatment, payment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I have read the Notice of Privacy Practices and understand my rights regarding my PHI.

Patient Consent Agreement for Chronic Care Services

I acknowledge that I have received a paper copy of the BIMGA Chronic Care Services Agreement.

Online Communications Informed Consent — Patient Portal

I acknowledge that I have received a paper copy of the BIMGA Online Communications Informed Consent Agreement — Patient Portal.

CONSENT & ACKNOWLEDGEMENTS (continued)

Notice of Privacy Practices

I acknowledge that the BIMGA Notice of Privacy Practices explains how the practice and its workforce may use and/or disclose protected health information about me for treatment, payment, healthcare operations, and as otherwise allowed by law. I understand BIMGA cannot be responsible for use or re-disclosure of information by third parties. I acknowledge that I have received a paper copy of the BIMGA Notice of Privacy Practices.

Office Policies & Procedures

I fully understand the office policies and procedures provided and stated in this New Patient Packet, including all codes of conduct and fees that could be assessed to me.

Patient Financial Agreement

I understand my financial obligation for services rendered by Beaumont Internal Medicine & Geriatric Associates as stated in the Financial Agreement Form provided to me.

Signature of patient or personal representative | Printed name of patient or personal representative | Date

Prescription History Consent

I voluntarily consent to provide Beaumont Internal Medicine & Geriatric Associates access to and use of my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes. I understand that my prescription history (including but not limited to prescriptions, labs, and other healthcare drug history) from multiple unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and may include prescriptions dating back several years.

I acknowledge that BIMGA may use health information exchange systems to electronically transmit, receive, and/or access my prescription history.

I understand that this Prescription History Consent will remain valid and in effect as long as I attend or receive services from BIMGA, unless revoked by me in writing, with such written notice provided to each practice site I attend or from which I receive services. **I certify that I have read this form, or that it has been read to me.**

PRINT NAME: _____ DATE OF BIRTH: _____ DATE: _____

SIGNATURE OF PATIENT / REPRESENTATIVE: _____ RELATIONSHIP TO PATIENT: _____

For patients requiring translation or a verbal reading of this document, the person reading or translating should document and sign below:

Reader / translator signature | Date

NURSE PRACTITIONER / PHYSICIAN ASSISTANT

CONSENT FOR TREATMENT

This facility has a Nurse Practitioner (NP) and Physician Assistant (PA) on staff to assist in the delivery of medical care. An NP or PA is not a doctor. An NP or PA is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, an NP or PA can diagnose, treat, and monitor acute and chronic diseases, as well as provide health-maintenance care.

"Supervision" does not require the constant physical presence of the supervising physician, but rather overseeing the activities of, and accepting responsibility for, the medical services provided.

An NP or PA may provide medical services that are within his or her education, training, and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Offering counseling and education
- Supplying sample medications and writing prescriptions
- Making appropriate referrals

I have read the above and hereby consent to the services of a physician assistant and/or nurse practitioner for my healthcare needs. I understand that at any time I can decline to see the physician assistant and/or nurse practitioner and request to see a physician.

Printed name	Signature	Date

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENT'S NAME: _____ DATE OF BIRTH: _____

SOCIAL SECURITY #: _____ PATIENT'S PHONE: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____

I REQUEST & AUTHORIZE (circle one): RELEASE MY INFO TO RELEASE MY INFO FROM the provider / facility below

◆ **NAME OF HEALTHCARE PROVIDER OR FACILITY TO RELEASE INFORMATION FROM / TO:**

PROVIDER / FACILITY: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ PHONE: _____ FAX: _____

Release to: Beaumont Internal Medicine & Geriatric Associates

755 N. 11th Street, Suite P-5200, Beaumont, TX 77702 • Ph: 409-898-2994 • Fax: 409-899-5542 • medicalrecords@bimga.com

The following information is to be disclosed:

Information Type	YES | NO
Physician notes	☐ ☐
Lab results	☐ ☐
Cardiac studies	☐ ☐
Pulmonary studies	☐ ☐
X-ray / diagnostic imaging reports	☐ ☐
Complete record	☐ ☐
Other:	☐ ☐

I understand my medical record may contain reports, test results, and notes that only a physician can interpret, and I should not contact my physician regarding entries in my record to prevent misunderstanding. I will not hold BIMGA liable for any misinterpretation resulting from not consulting my physician. My record may include information relating to sexually transmitted diseases, HIV/AIDS, behavioral or mental health services, or treatment for alcohol and drug abuse. **Right to revoke:** I may revoke this authorization in writing at any time; revocation will not apply to information already released. **Other rights:** I may inspect or obtain a copy of the information used or disclosed. **Expiration:** By initialing here: _____ I certify that this authorization will remain valid indefinitely unless revoked by me in writing. I understand that if I choose not to initial here, this authorization will expire in six months.

_____ _____

Signature of patient or legal representative Date

_____ _____

Printed name of patient If signed by representative, relationship to patient

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PATIENT MEDICATION AGREEMENT

Due to DEA regulations, the following guidelines will be strictly followed for all patients taking controlled medications of any kind:

- A urine drug screen will be performed at least twice a year.
- Patients may choose ONE pharmacy for their controlled medications, which will be listed below. If the pharmacy needs to change, it is the patient's responsibility to notify our office in a timely manner and update the pharmacy information on this form.
- Patients MUST be seen by a provider (NP, PA, or doctor) EVERY THREE MONTHS.
- Patients MUST be seen by the doctor at least once a year to continue receiving refills for controlled medication. If a patient cancels or no-shows for a follow-up appointment, the controlled medication will not be refilled until the patient is seen.
- Patients are expected to schedule follow-up appointments before leaving our office. There will be no work-in appointments for controlled-medication refills; it is the patient's responsibility to schedule the 3-month follow-up.
- Controlled medications will be refilled every 30 days. Please contact our office within 24 hours of your refill date (unless the due date falls on a Sunday).

We apologize for any inconvenience this may cause. As a clinic, we must comply with DEA regulations, especially regarding controlled medications. If you have any questions or concerns, please feel free to discuss them at your appointment.

I agree to use _____ pharmacy, located at _____, for filling all of my controlled medications.

I understand my doctor and the pharmacy will cooperate fully with any city, state, or federal law-enforcement agency or regulatory board in investigating any possible misuse, sale, or other diversion of my controlled medication(s). I authorize the provision of this Agreement to my pharmacy, and I agree to waive any applicable right to privacy or confidentiality with respect to these authorizations.

I agree to use my medicine at a rate no greater than prescribed. I will not attempt to obtain controlled medications from other physicians. I will not share, sell, or trade my medications with anyone. I will not use any illegal controlled medications. I will safeguard my medications from loss or theft; lost or stolen medications will NOT be replaced.

I agree to follow these guidelines, which have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document will be given to me.

THIS AGREEMENT WAS ENTERED ON (DATE): _____

_____ Patient signature

_____ Patient name (please print)

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION

HIPAA

I, _____ (patient name), give permission to Beaumont Internal Medicine & Geriatric Associates to discuss my medical information with the following individuals:

Name	Phone	Email	Relationship

Relationship options: Spouse • Parent • Child • Grandchild • Caregiver • Friend • POA/Guardian • Other

Patient signature _____ Date _____

Patient Consent Agreement for Chronic Care Services

Medicare offers a benefit for patients with multiple chronic diseases. By consenting to this Agreement, you designate your provider to furnish chronic care management (CCM) services per the applicable rule.

Only patients with more than one chronic condition are eligible for this benefit, and your provider agrees not to bill Medicare for this service if you do not have more than one chronic condition. Medicare defines a chronic condition as one that is expected to last at least 12 months and that increases the risk of death, acute exacerbation of disease, or a decline in function.

As part of this benefit, your provider agrees to make available the following services:

- 24/7 access to a healthcare provider to address your acute chronic-care needs
- Use of certified EHR software to document your care
- A written or electronic version of your care plan
- Medication reviews and oversight
- Assistance in managing transitions of care from one provider to another

In connection with this benefit, your provider agrees to bill Medicare just once per each 30-day billing cycle. If you revoke this Agreement, your provider will give you written confirmation of the revocation, stating its effective date.

PATIENT PORTAL & ONLINE COMMUNICATIONS

Chronic Care Services — Consent Terms

By signing this Agreement, you agree to the following terms required by Medicare:

- You consent to your provider furnishing CCM services to you.
- You acknowledge that only one practitioner can furnish CCM services to you during a 30-day period.
- You authorize electronic communication of your medical information with other treating providers to coordinate your care.
- You understand that the Medicare co-insurance amount applies to CCM services.
- You may stop CCM services at any time by revoking this Agreement, effective at the end of the then-current 30-day period, by notifying our practice in writing.

Signature _____ Print name _____ Date _____

Online Communications Informed Consent — Patient Portal

SECURE EMAIL ADDRESS: _____ **PATIENT NAME:** _____

DOB: _____

Complete the following if the email address does not belong to the patient. **Please note: portal access is not available for patients aged 13–18.**

NAME OF PARENT / GUARDIAN REQUESTING ACCESS: _____

RELATIONSHIP TO PATIENT: _____ **DATE:** _____

OUR WEBSITE
www.bimga.com

PATIENT PORTAL
https://health.healow.com/bimga

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with online communications between my physician and me, and I consent to the conditions outlined herein. I agree to follow the instructions set forth herein, as well as any other instructions my physician may impose for communicating via online communications. I have had a chance to ask questions and receive answers, and I have been proactive about asking questions related to this consent agreement. All of my questions have been answered, and I understand and concur with the information provided.

Signature of patient / parent / guardian _____ Date _____

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YEARLY PREVENTIVE VISITS

When you come in for your yearly preventive visit, your insurance company will be billed for a **PREVENTIVE EXAM**, which is covered by most insurances at 100%. During your **PREVENTIVE EXAM**, if other problems are discussed with the provider — such as elevated blood pressure, cholesterol issues, diabetes, or any other illness — your insurance company will also be billed for a **REGULAR OFFICE VISIT**, which could be applied toward your co-pay or deductible. These billing procedures are not dictated by this office, but by government agencies that structure correct coding. If you have any questions, please contact our billing department.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

ARTIFICIAL INTELLIGENCE (AI) USE NOTIFICATION & CONSENT

Our office uses an artificial intelligence (AI) ambient documentation system (Sunoh.ai) to help document your visit. This secure voice software system securely records and transcribes the patient/provider discussion. Your privacy is protected and the system is HIPAA compliant. Recordings are transcribed directly into your chart and are not part of the public internet. Only Beaumont Internal Medicine & Geriatric Associates (BIMGA) can access these records.

By initialing here, you consent to AI use by your provider:

PATIENT INITIALS: _____

ACKNOWLEDGEMENT

I have read and understand this notification regarding the use of AI-assisted documentation during my visit. I understand that I may ask my provider questions about this technology, or decline its use, at any time.

Printed name of patient or personal representative	Signature of patient or personal representative	Date

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HOW TO RETURN YOUR PAPERWORK

CHOOSE ONE OF THE FOLLOWING

EMAIL
newpatient@bimga.com

FAX
409-898-2592

DROP OFF
755 N. 11th St., Suite P-5200, Beaumont, TX 77702

MAIL
755 N. 11th St., Suite P-5200, Beaumont, TX 77702

ONCE YOUR PAPERWORK IS RECEIVED, A NEW PATIENT COORDINATOR WILL:

- Review your paperwork
- Verify your insurance
- Submit your information to the doctor for review
- Create your chart
- Call you to schedule an appointment

TO ENSURE A QUICK AND SEAMLESS PROCESS:

- Fill out the paperwork completely
- Include your insurance information (cards, if possible)
- Change your primary care provider with your insurance company — for HMO plans, this must be done before an appointment can be scheduled

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THANK YOU!

FOR QUESTIONS, E-MAIL

newpatient@bimga.com