BIMGA
BEAUMONT INTERNAL MEDICINE & GERIATRIC ASSOCIATES

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# *NEW PATIENT HEALTH INFORMATION*

*(PLEASE USE BLUE OR BLACK INK)*

**DOCTOR:** _____ **TODAY'S DATE:** _____

**NAME:** _____ **DATE OF BIRTH:** _____

**SEX: (CIRCLE ONE) MALE FEMALE SOCIAL SECURITY #:**_____

**EMAIL:** _____

**ADDRESS:** _____ **CITY/STATE:** _____ **ZIP:** _____

**PHONE #:** _____ **ALTERNATE #:** _____

**REFERRED BY:** _____

**MARITAL STATUS: (CIRCLE ONE) SINGLE MARRIED WIDOWED DIVORCED**

**EMPLOYER:** _____ **PHONE:** _____

**NEAREST RELATIVE:** _____ **PHONE:** _____

**RELATIONSHIP:** _____

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**PREVIOUS PRIMARY CARE PHYSICIAN:** _____

**HAVE YOU SEEN YOUR PRIMARY CARE PHYSICIAN IN THE LAST 2 YEARS? YES or NO**

**HOW OFTEN DO YOU SEE YOUR PRIMARY CARE PHYSICIAN?** _____

**REASON CHANGING PHYSICIANS:** _____

**HAVE YOU EVER BEEN DISCHARGED FROM ANOTHER PRACTICE? YES or NO**

**DO YOU CHANGE PHYSICIANS FREQUENTLY? YES or NO**

**HOW MANY TIMES HAVE YOU BEEN ADMITTED TO THE HOSPITAL IN THE LAST YEAR?** _____

**WHAT SPECIALISTS DO YOU SEE?** _____

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**INSURANCE NAME:** _____ **INSURANCE PHONE #:** _____

**MEMBER ID #:** _____ **GROUP #:** _____

***IT IS REQUIRED FOR YOU TO COMPLETE ALL THE TABLES BELOW. IF IT DOESN'T APPLY STATE "NONE".***

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

| Current Medical Issues | How Long? |
|---|---|
| | |
| | |
| | |
| | |
| | |
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**• PAST HISTORY: List all serious illnesses, injuries and operations.**

| Procedure/Illness | Year |
|---|---|
| | |
| | |
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| | |

**• List ALL medications including vitamins/herbal supplements.**

| Name of Medication | Dosage | Prescribing Physician |
|---|---|---|
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**ALLERGIES:** _____

# Circle YES or NOto the following questions.

**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 any type of 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, bronchitis, etc.?) _____ | YES | NO |
| Do you smoke? Pack/day? _____ | YES | NO |

**CARDIOVASCULAR:**

| | | |
|---|---|---|
| Has a Dr. ever said that you had heart trouble? | YES | NO |
| Has a Dr. ever said that you have high blood pressure? | YES | NO |
| Have you ever had rheumatic fever? | YES | NO |
| Do you get tired easily or short of breath? | YES | NO |
| Do your ankles swell at times? | YES | NO |

**GI:**

| | | |
|---|---|---|
| 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 partake in recreational drugs? | YES | NO |
| Have your bowel habits changed in the past year? | YES | NO |

**GU:**

| | | |
|---|---|---|
| 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 seem to be tense and nervous all the time? | YES | NO |
| Have you ever been a patient in amental health facility? | YES | NO |

## FAMILY HISTORY:
## PLEASE CIRCLE THE STATE OF HEALTH FOR THE FOLLOWING PEOPLE.
## IF DECEASED PLEASE GIVE THE CAUSE OF DEATH:

**SPOUSE:GOOD FAIR POOR DECEASED: CAUSE OF DEATH: _____**

**FATHER:GOOD FAIR POOR DECEASED: CAUSE OF DEATH: _____**

**MOTHER:GOOD FAIR POOR DECEASED: CAUSE OF DEATH: _____**

**SISTERS:GOOD FAIR POOR DECEASED: CAUSE OF DEATH: _____**

**BROTHERS:GOOD FAIR POOR DECEASED: CAUSE OF DEATH: _____**

## HAS ANYONE IN YOUR FAMILY HAD ANY OF THE FOLLOWING DISEASES?

| | | |
|---|---|---|
| **SUGAR DIABETES** | **YES** | **NO** |
| **T.B. (Tuberculosis)** | **YES** | **NO** |
| **HEART TROUBLE** | **YES** | **NO** |
| **HIGH BLOOD PRESSURE** | **YES** | **NO** |
| **EPILEPSY** | **YES** | **NO** |
| **SEVERE RHEUMATISM** | **YES** | **NO** |
| **CANCER** | **YES** | **NO** |
| **Has anyone in your family ever been a patient in a mental hospital?** | **YES** | **NO** |
| **Has anyone in your family ever committedsuicide?** | **YES** | **NO** |

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## FOR WOMEN ONLY:

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

**Have you ever had a miscarriage? YES NO**

**When was your last menstrual period? _____**

**Do your periods come at regular intervals? YES NO**

**When was your last pregnancy? _____**

**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 FOR BY INSURANCE. I HEREBY AUTHORIZE BEAUMONT INTERNAL MEDICINE & GERIATRIC ASSOCIATES TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.**

**CO-PAYS, CO-INSURANCE AND DEDUCTABLES ARE DUE THE DAY OF SERVICE. PLEASE REVIEW OUR FINANCIAL POLICIES FOR FURTHER INFORMATION.**

**NAME OF PRIMARY INSURANCE: _____**

**ID #: _____**

**GROUP #: _____**

**NAM E OF SECONDARY INSURANCE: _____**

**ID #: _____**

**GROUP #: _____**

_____

**Printed name of Patient or Personal Representative**

**(If PR. Please list relationship)**

_____

**Signature of Patient or Personal Representative**

_____

**DATE**

## PLEASE INITIAL ON EACH LINE BELOW.

_____ **(Patient's Initials)**

### PRESCRIPTION HISTORY CONSENT

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

_____ (Patient's Initials)

### CERTIFIED NURSE PRACTITIONER / CERTIFIED PHYSICIAN ASSISTANT

I understand that certain care maybe provided by a Certified NPor a Certified PAemployed by Beaumont Internal Medicine and Geriatric Associates as stated in the Nurse Practitioner Consent Form provided.

_____ **(Patient's Initials)**

### AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

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

_____ **(Patient's Initials)**

### PATIENT CONTROLLED SUBSTANCES & PAIN MANAGEMENT AGREEMENT

I fully understand the purpose of the Patient Controlled Substances & Pain Management Agreement is to prevent misunderstandings about certain medicines I will be taking for pain management, anxiety and/or sleep disorders. This is to help both myself and my doctor comply with the law regarding controlled pharmaceuticals.

_____ **(Patient's Initials)**

### AUTHORIZATION TO DISCUSS MEDICAL INFORMATION

I understand that by completing the, Authorization To Discuss Medical Information Form, I have Authorize the Use or Disclosure of Protected Health Information (PHI) *(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164).* Beaumont Internal Medicine & Geriatric Associates may use or disclose PHI as per the terms listed on the Notice of Privacy Practices. The effective period for this permission is from time of this signature moving forward. I understand I have the right to revoke this authorization, in writing, at any time. The PHI are including but not excluded to records relating to mental healthcare, communicable disease, HIV/ AIDS, pregnancies, or treatment of alcohol or drug abuse. I understand that 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 patient rights regarding my PHI.

_____ **(Patient's Initials)**

### PATIENT CONSENT AGREEMENT FOR CHRONIC CARE SERVICES

I acknowledge I have received a paper copy of the Beaumont Internal Medicine & Geriatric Associates-Chronic Care Services Agreement.

_____ **(Patient's Initials)**

### ONLINE COMMUNICATIONS INFORMED CONSENT-PATIENT PORTAL

I acknowledge I have received a paper copy of the Beaumont Internal Medicine & Geriatric Associates-ONLINE COMMUNICATIONS INFORMED CONSENT AGREEMENT– PATIENT PORTAL.

_____ **(Patient's Initials)**

### NOTICE OF PRIVACY PRACTICES

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

_____ **(Patient's Initials)**

### OFFICE POLICIES & PROCEDURES

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

_____ **(Patient's Initials)**

### PATIENT FINANCIAL AGREEMENT

I understand my financial obligation for services rendered by Beaumont Internal Medicine and Geriatrics Associated 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 prescriptionmedication history from other healthcare providers or third party pharmacy benefit payers fortreatment purposes. I understand that my prescription history (which includes but is not limitedto prescriptions, labs, and other health care drug historical information) from multiple otherunaffiliated medical providers, insurance companies, and pharmacy benefit managers may beviewable by my providers and staff here, and it may include prescriptions dating back for severalyears.

I acknowledge that Beaumont Internal Medicine & Geriatric Associates may use health information exchange systems toelectronically transmit, receive and/or access my prescription history.

I understand that this Prescription History Consent will be valid and remain in effect as longas I attend or receive services from Beaumont Internal Medicine & Geriatric Associates, unless revoked by me in writing with suchwritten notice provided to each practice site I attend or from which I receive services.

I certify that I have read this form or it has been read to me.

_____
Date

_____ _____
Print Name Date of Birth

_____
Signature of Patient/Legally Authorized Representative

_____
Relationship to Patient (If patient not signing)

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

_____
Reader/Translator Signature Date

# Nurse Practitioner (N.P.)/ Physician Assistant (P.A.) Consentfor Treatment

This facility has on staff a N.P. /P.A. to assist in the delivery of medical care.

Nurse Practitioners (N.P.) / Physician Assistants (P.A.) arenot a doctor. A N.P. / P.A. are a graduate of a certified training program and are licensed by the state board. Under the supervision of a Physician, a N.P. / P.A. 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 theactivities of an accepting responsibility for the medical services provided.

A N.P. / P.A. may provide such medical services that are within his/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 myhealth care needs.

I understand that at any time I can refuse to see the physician assistant and/or nurse practitioner and request to see aphysician.

_____
Printed Name

_____ _____
Signature Date

## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Social Security #: _____ Patient's Phone: _____

Patient's Address:_____ City:_____ State:_____ Zip:_____

**I request and authorize:**

**Name of healthcare provider(s) or facility to release information:**

_____

Address: _____ City: _____

State:_____ Zip: _____ Phone: _____ Fax: _____

**To release healthcare information on the patient named above to:**

# Beaumont Internal Medicine & Geriatric Associates

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

**Fax: 409-899-5542**

The following information is to be disclosed:

| Yes | No | |
|---|---|---|
| □ | □ | physician notes |
| □ | □ | lab results |
| □ | □ | cardiac studies |
| □ | □ | pulmonary studies |
| □ | □ | x-ray/diagnostic imaging reports |
| □ | □ | complete record |
| □ | □ | other_____ |

I understand that my medical record may contain reports, test results & notes that only a physician can interpret. I understand I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding the information.

I will not hold Beaumont Internal Medicine & Geriatric Associates liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for his/her interpretation.

I understand the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency (HIV). It may also include information about behavioral or mental health services or treatment for alcohol &drug abuse.

**Right to revoke:** I understand I have the right to revoke this authorization at any time. I understand my revocation must be in writing. I understand the revocation will not apply to information already released.

**Other rights:** I understand I may inspect or obtain a copy of the information to be used or disclosed.

**Expiration:** Unless otherwise revoked, this authorization will expire on the following date, event, or condition. (If an expiration date, event or condition is not specified, this authorization will expire in 6 months). DATE OF EXPIRATION: _____

Signature of Patient or Legal Representative:_____

If signed by representative, what is relationship?_____

Date:_____

# PATIENT MEDICATION AGREEMENT

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

- Urine Drug Screen at least twice a year
- Patients may choose ONE pharmacy for their controlled medications to be filled at, which will be listed below in this agreement. If for any reason the pharmacy needs to be changed, it is the patient's responsibility to notify our office in a timely manner as well as updating the pharmacy information on this form.
- Patients MUST be seen by a provider EVERY THREE MONTHS (NP, PA, or Doctor)
- MUST be seen by the Doctor at least once a year in order to continue to receive refills for their controlled medication. If patients cancels or no-show for their follow-up appointment, their controlled medication will not be refilled until they are seen.
- Patients are expected to schedule their follow-up appointments before leaving our office after current visit. There will be no work-in appointments for controlled medication refills. It is the patient's responsibility to schedule their 3 month follow-up appointments.
- Controlled medications will be refilled every 30 days, please contact our office within 24 hours of your medication refill date (unless due date falls on a Sunday)

We apologize for any inconvenience this may cause. We, as a clinic, hope you understand that due to the DEA regulations, we have to be in compliance, especially in regards to controlled medications. If you have any questions or concerns, please feel free to discuss at your appointment.

**I AGREE TO USE _____ PHARMACY LOCATED**

**AT _____ FOR FILLING ALL MY CONTROLLED MEDICATIONS**

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

I agree I will use my medicine at a rate no greater than the prescribed rate. I will not attempt to obtain any controlled medications for 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 that 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, _____, give permission to Beaumont
(PATIENT NAME)

Internal Medicine & Geriatric Associates to discuss any of my medical information with the following individuals:

Name:_____Phone:_____

Email :_____

Relationship*: Spouse Parent Child Grandchild Caregiver Friend POA/Guardian Other*:_____

Name:_____Phone:_____

Email :_____

Relationship*: Spouse Parent Child Grandchild Caregiver Friend POA/Guardian Other*:_____

Name:_____Phone:_____

Email :_____

Relationship*: Spouse Parent Child Grandchild Caregiver Friend POA/Guardian Other*:_____

Name:_____Phone:_____

Email :_____

Relationship*: Spouse Parent Child Grandchild Caregiver Friend POA/Guardian Other*:_____

_____ _____

**PATIENT SIGNATURE** **DATE**

# Patient Consent Agreement for Chronic Care Services

Medicare now offers a new benefit for patients with multiple chronic diseases, and by consentingto this Agreement, you designate your provider, Dr. _____"*Provider*", toprovide chronic care management (CCM) services per the new 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 don't 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.

**Provider Chronic Care Services**

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

1. 24/7 access to a healthcare provider to address your acute chronic care needs
2. Use of certified EHR software to document your care
3. Provide a written or electronic version of your care plan
4. Perform medication reviews and oversight
5. Assist in the management of transitions of care from one provider to another

In connection with this new benefit, your provider agrees to bill Medicare just one time per each 30-day billing cycle and if you revoke this Agreement, provide you with a written confirmation of the revocation, stating the effective date of the revocation.

**Consent Terms**

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

1. You consent to your Provider providing CCM services to you.
2. You acknowledge that only one practitioner can furnish CCM Services to you during a thirty (30)-day period.
3. You authorize electronic communication of your medical information with other treating providers to facilitate the coordination of your care.
4. You understand that the Medicare Co-Insurance amount applies to CCM Services.
5. You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then-current thirty 30-day period of services by notifying our practice in writing.

**Signature:**_____ **Print Name:**_____

**Date:** _____

# PATIENT ACKNOWLEDGEMENT/ CONSENT
# 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 years.

_____
Name of Parent/Guardian requesting access

_____ _____
Relationship to the Patient Date

Our Patient Portal site may be accessed by two different URL's.

**Our Website:** www.bimga.com

**Patient Portal direct site:** **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 consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, as well as any other instructions that my physician may impose to communicate with patients via online communications. I have had a chance to ask any questions that I had and to receive answers. 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 in the answers.

_____ _____
Signature of Patient /Parent/Guardian Date

# YEARLY PREVENTIVE VISITS

When you are 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 illnesses, your insurance company will also be billed for a REGULAR OFFICE VISIT which could go towards your co-pay or deductible. These billing procedures are not dictated by this office but by government agencies which structure correct coding. If you have any questions, please contact our billingdepartment.

PRINT NAME: _____

SIGNATURE: _____

DATE:_____

# ANNUAL EXAM

NAME: _____ DATE: _____

DATE OF BIRTH: _____

1. Do you see any specialists? YES OR NO
   If yes, who? _____

2. Do you have any of the following? (Please circle all that apply)

   + CPAP +BIPAP +OXYGEN MACHINE +NEBULIZER +NONE

3. Do you use any of the following? (Please circle all that apply)

   +HOME HEALTH +PRIVATE CARE PROVIDER
   +ASSISTED LIVING FACILITY +NONE

4. Do you have any of the following? (Please circle all that apply)

   +LIVING WILL +MEDICAL POWER OF ATTORNEY +ADVANCED DIRECTIVE
   +NONE

5. If you were unable to speak for yourself, and you had little chance of recovery, who best understands the type of care you would want? _____

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

7. What type of care would you or a loved one choose for a situation like a "stroke"? (Please circle all that apply)

   +PRIVATE CARE PROVIDER +HOME HEALTH +HOSPICE
   +SKILLED NURSING +ASSISTED LIVING +OTHER_____

8. HAVE YOU BEEN HOSPITALIZED IN THE LAST YEAR? YES OR NO
   If yes, explain: _____

9. Do you use any of the following? (Please circle all that apply)
   +CANE +WALKER +WHEELCHAIR +POWER LIFT CHAIR +LIFT CHAIR +NONE

10. Have you had any falls in the last year? YES OR NO
11. Is your home safe (mobility wise) & are you able to get around at home? YES OR NO
12. Do you have any trouble feeding or bathing yourself? YES OR NO
13. Do you require help to leave your home? YES OR NO
14. Are able to cook, manage your own money and prepare your medications? YES OR NO
15. Have you had any urinary incontinence (even a little) in the last 3 months? YES OR NO

16. How active are you now compared to the last year?
    +MORE ACTIVE  +LESS ACTIVE  +SAME

17. Do you experience pain in your day to day life? YES OR NO
18. On a scale of 1 to 10, how would you rate your pain? _____
19. When experiencing pain, how do you control it? _____
20. Do you take all your medications as prescribed? YES OR NO
21. Do you keep all your doctor appointments? YES OR NO

22. When was your last Bone Density? _____
    Results: +OSTEOPENIA +OSTEOPOROSIS +NORMAL

23. Have you had the circulation in your legs checked? YES OR NO

24. List the last time you had the following vaccines:
    - INFLUNZA: _____
    - PNEUMONIA: _____
    - TETANUS: _____
25. Have you ever had a Hepatitis B series? YES OR NO
26. Have you been tested for Hepatitis C? YES OR NO
    If yes, results? +POSITIVE +NEGATIVE
27. Do you wish to be tested? YES OR NO

28. When was your last eye exam? _____
29. Who is your optometrist (eye doctor)? _____
30. Do you have any of the following? (Please circle all that apply)
    +CATARACTS +GLAUCOMA +ASTIGMATISM +MACULAR DEGENERATION
    +NONE
31. Do you wear prescription glasses or contacts?
    +GLASSESS  +CONTACTS +BOTH  +NONE

32. Do you have hearing aids? YES OR NO

33. When was your last colonoscopy? _____
34. What were the results? +POLYPS  +DIVERTICULITIS  +NORMAL

MEN ONLY:
35. Have you had a prostate exam in the last year? YES OR NO

WOMEN ONLY:
36. When was your last mammogram? _____
    What was the result? NORMAL OR ABNORMAL
37. Do you perform self breast exams? YES OR NO
38. When was your last pap smear? _____

# HOW TO RETURN PAPERWORK

## CHOOSE ONE OF THE FOLLOWING:

- Email to arobles@bimga.com
- Fax to 409-898-2592
- Drop off at 755 N 11th St Suite P5200 Beaumont TX 77702
- Mail to 755 N 11th St Suite P5200 Beaumont TX 77702

## ONCE THE PAPERWORK HAS BEEN RECEIVED A NEW PATIENT COORDINATOR WILL:

- Review paperwork
- Verify insurance
- Submit to doctor for review
- Make a chart
- Call to schedule an appointment

## TO ENSURE A QUICK AND SEAMLESS PROCESS:

- Fill paperwork out completely
- Include insurance information (cards if possible)
- Change you primary care provider with insurance company (this has to be done prior to an appointment being made for HMO plans)