Carl A. Willeford Jr. MSN, FNP-C
Family Nurse Practitioner

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Date: ____________/____________/____________ Marital Status: S D M W

Last Name: ________________________________ First Name: ________________________________

DOB: __________/__________/__________ Age: __________ Sex: _____Male or _____Female

Mailing Address: ____

City: ____ State: ____________ Zip: ______________

Home#: (__________) __________-____________ Cell#: (__________) __________-____________

Employer: ______________________________________ SS#: __________-__________-__________

Race: ____________________ Email: ____

Pharmacy: ____

If patient is a minor or student, parent name: ____________________________________

Emergency Contact:
Name: ____ Relation to patient: ______________________

Home#: (__________) __________-____________ Cell#: (__________) __________-____________

Primary Insurance Information:

Insurance Name: ____

Policy#: ____ Group#: ______________________________

Name of Insured: ____

DOB: ____________/____________/____________ SS#: __________-__________-__________

Patient Signature: ____

Patient Name: ______________________________________ DOB: _________/_________/__________

How did you hear about us?

In order to properly thank our referring friends, please let us know where you heard about us by checking the appropriate boxes below. Please check all that apply.

☐-I'm A Former Patient

☐- Nacogdoches Family Medicine Website

☐- Your ad in Charm Magazine

☐- Your ad/listing in the phone book

☐-La Lengua Newspaper

☐- Nacogdoches Daily Sentinel

☐- Facebook

☐- Google Search

☐-Recommendation of my employer or someone at work:(who)_________________________________

☐-Recommendation of a friend:(who)____

☐-Recommendation of a relative:(who)____

☐-Other: ____

NACOGDOCHES
FAMILY MEDICINE

Patient Name: ____ DOB: ________/________/________

Drug Allergies? ____

List any medications you are taking regularly. (Include over the counter, herbal, or natural remedies)

________ No Current Medications

Medication	Dosage	How often you take it

New Patient Health Questionnaire

Patient Name: ____ DOB: ________/________/________

Allergies: ____

Do you smoke? Yes or No
If Yes, How Much? _________________________

Do you drink alcohol? Yes or No
If Yes, How Much? _________________________

Have you ever had or been diagnosed to have any of the following?

______ Allergies
______ Anemia
______ Asthma
______ Bleeding Disorder
______ Cancer
______ Cataracts
______ Chicken Pox
______ Depression
______ Diabetes
______ Digestive Disorder
______ Epilepsy
______ Glaucoma
______ Heart Attack
______ Heart Disease
______ Hemorrhoids
______ High Blood Pressure
______ High Cholesterol
______ Kidney Disease
______ Liver Disease
______ Pleurisy
______ Pneumonia
______ Prostate Problems
______ Stroke
______ Syphilis
______ Thyroid Disease
______ Tuberculosis
______ Ulcers

Hospitalizations or Surgeries

Reason	Date

Family History

Illness	Relative

Family Health Status

Relative	Birth Year	Alive?	Age at Death	Illness
Father				
Mother				
Brother				
Sister				

Please indicate if you've had recurrent or recent significant change in any of the following:

Yes	No	**Cardiovascular**
___	___	Chest Pain
___	___	Heart Trouble
___	___	Palpitations
___	___	SOB with walking
___	___	Swelling feet, ankles or hands
___	___	Waking at night with SOB

Yes	No	**Constitutional Symptoms**
___	___	Frequent headaches
___	___	Recent weight change
___	___	Unusual fatigue or weakness

Yes	No	**Ears/Nose/Mouth/Throat/Neck**
___	___	Bleeding gums
___	___	Chronic sinus problems
___	___	Difficulty swallowing
___	___	Hearing aids
___	___	Earaches or drainage
___	___	Hearing loss
___	___	Lumps or swollen glands in neck
___	___	Mouth sores
___	___	Neck pain
___	___	Nose bleeds
___	___	Sore throat

Yes	No	**Endocrine**
___	___	Change in hand size
___	___	Excessive skin dryness
___	___	Excessive thirst or urination
___	___	Glandular or hormone problem
___	___	Heat or cold intolerance

Yes	No	**Eyes**
___	___	Blurred or double vision
___	___	Change in vision
___	___	Eye disease
___	___	Wear glasses

Yes	No	**Gastrointestinal**
___	___	Abdominal pain
___	___	Black or tarry stools
___	___	Change in bowel movements
___	___	Frequent diarrhea
___	___	Loss of appetite
___	___	Nausea or vomiting
___	___	Painful bowel movements
___	___	Rectal bleeding or blood in stool

Yes	No	**Genitourinary**
___	___	Blood in urine
___	___	Burning or pain on urination
___	___	Change in force or strain when urinating
___	___	Frequent urination
___	___	Incontinence or dribbling of urine
___	___	Irregular periods
___	___	Painful periods
___	___	Recurrent vaginal discharge
___	___	Sexual difficulties
___	___	Testicular pain

Yes	No	**Hematologic/Lymphatic**
___	___	Bleeding or bruising tendency
___	___	Recurrent anemia
___	___	Slow to heal after cuts or wounds
___	___	Swelling, warmth and tenderness of veins

Yes	No	**Integument (skin/breast)**
___	___	Breast discharge
___	___	Breast lump
___	___	Breast pain
___	___	Change in hair or nails
___	___	Change in skin color
___	___	Rashes or itching
___	___	Varicos veins

Yes	No	**Musculoskeletal**
___	___	Back pain
___	___	Cold hands and feet
___	___	Difficulty in walking
___	___	Joint pain or stiffness
___	___	Muscle pain or cramps
___	___	Weakness

Yes	No	**Neurological**
___	___	Convulsions
___	___	Head injury
___	___	Light headedness or dizziness
___	___	Numbness or tingling sensation
___	___	Paralysis
___	___	Stroke
___	___	Tremors

Yes	No	**Psychiatric**
___	___	Depression
___	___	Insomnia
___	___	Memory Loss
___	___	Nervousness

Nacogdoches Family Medicine HIPAA Agreement

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY OF FRINEDS INVOLVED IN MY CARE. THIS AUTHORIZATION MAY NOT BE USED TO RELEASE OR OBTAIN DOCUMENTED INFORMATION.

Patient Name: ______________________________ SS#: ______/______/______ DOB: ______/______/______

AT MY REQUEST, I AUTHORIZE NACOGDOCHES FAMILY MEDICINE TO DISCLOSE MY DIAGNOSIS, RESULTS OF EXAMS OR PROCEDURES, DIAGNOSTIC TESTS, OR PROCEDURES, OPERATIVE PATHOLOGY, RADIOLOGY REPORTS, AND CONSULTATION REPORTS TO THE INDIVIDUALS LISTED BELOW WHO WILL BE DIRECTLY INVOLVED IN MY CARE AND TREATMENT.

I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and is no longer protected by state and federal privacy laws.
I understand that treatment at Nacogdoches Family Medicine will not be denied if I do not sign this authorization.
I may not revoke this authorization to the extent that Nacogdoches Family Medicine has taken action in reliance on the authorization.

	Name	Relationship	Phone
1			
2			
3			
4			
5			

Signature of Patient or Legal Representative: ______________________________ Date: ______/______/______

Witness: ____ Date: ______/______/______

Revocation of Authorization

I, __________________, hereby revoke or cancel this authorization effective on this date: _____/_____/_____

Signature of Patient or Legal Representative: ______________________________ Date: ______/______/______

Witness: ____ Date: ______/______/______

Appointment No-Show Policy

Nacogdoches Family Medicine seeks to provide compassionate care to all of our patients in a timely fashion. Therefore, last-minute appointment cancellations and no-shows for appointments have a significant potential negative impact on care for others who might need to be treated in our clinic but could not get an appointment time that day. We understand that issues can arise, but due to an increasing number of late cancellations or no-shows, we have instituted a cancellation/no-show policy.

Any patient who misses an appointment without contacting Nacogdoches Family Medicine 24 hours in advance will incur a $25.00 cancellation fee. Patients who continue to cancel or no-show may be dismissed from the practice at the discretion of the provider. Dismissal is based primarily on conduct. If you are dismissed from the practice, your remaining scheduled appointments will be cancelled. Only emergency medical treatment will be offered within the first 30 days of dismissal. Reapplication to the practice after a six-month period following the initial dismissal letter will be considered by your medical provider.

Thank you,

Nacogdoches Family Medicine

I have read the Appointment No-Show Policy and understand that if I do not call 24 hours in advance of my scheduled appointment, I will be charged a $25.00 cancellation/no-show fee.

____ ____________/____________/____________

Patient Signature Date