PATIENT REGISTRATION
(PLEASE PRINT CLEARLY)

Date _____

Preferred Provider (please circle):

Dr. Robert Nobles, Deborah Nobles PA-C

Patient _____ **Preferred First Name** _____
Last Name First Name Middle Initial

Age _____ **Birth Date** _____ **Sex** (circle) M / F **Patient Social Security #** _____-_____-_____

Preferred Spoken Language (circle one) English / Spanish / _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Street Address _____

City _____ **State** _____ **Zip** _____

Phone: Home _____ **Work** _____ **Cell** _____

Email Address _____ **Primary Phone** (circle) Home / Work / Cell

Preferred Method of Communication: Phone / Email / Mail / Patient Portal

Preferred Method of Office Notifications: None / Phone / Text Messaging / Email

Do you have any communication needs? If yes, please explain _____

Responsible Party (if a minor) _____ **Relationship to Patient** _____

Patient Employed By _____

Business Address _____

Occupation _____ **Phone** _____

Spouse (or responsible party) Name _____ **Birth Date** _____

Business Name and Address _____

Occupation _____ **Phone** _____

Spouse's Social Security # _____

How did you learn about Nobles Internal Medicine? _____

Local Pharmacy _____ **Phone** _____

Mail In Pharmacy _____ **Phone** _____

Do you have Medical Insurance? (circle one) Yes / No

Name of Primary Insurance _____ **ID #** _____ **Group #** _____

Name of Secondary Insurance (if any) _____ **ID #** _____ **Group #** _____

☐ Medicare ☐ Medicaid **Claim ID #** _____

In case of emergency, who should be notified? _____ **Phone** _____

Please list individuals authorized to receive detailed information regarding your appointments, treatments, prescriptions, or labs: _____

May we leave a message on your: Home Voicemail? (circle) Yes / No Cell Phone Voicemail? (circle) Yes / No

(ALL INFORMATION IS STRICTLY CONFIDENTIAL)

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following:

	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

HOSPITALIZATIONS/PROCEDURES

Year	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion?

☐ Yes ☐ No

If yes, please give approximate dates: _____

SERIOUS ILLNESS/INJURIES	Date	Outcome

PREGNANCY HISTORY

Year of Birth	Complications, if any

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Substance	How much used
	Caffeine	
	Tobacco	
	Drugs	
	Alcohol	
	Other:	
	Other:	

OCCUPATIONAL CONCERNS

Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other:
	Other:

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date

_____ _____

Reviewed By Date

HEALTH HISTORY
(CONFIDENTIAL)

Nobles Internal Medicine

5282 Medical Drive, Suite 110, San Antonio, TX 78229

Name _____ Today's Date _____

Preferred Name _____

Age _____ Birthdate _____ Date of last physical examination _____

What is the reason for your visit? _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

SKIN

- ☐ Bruise easily
- ☐ Skin cancer
- ☐ Itching
- ☐ Bleeding
- ☐ Change in mole
- ☐ New skin lesion
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

CONDITIONS Check (✓) conditions you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Pneumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

PHARMACY

Local: _____ **Phone:** _____

Mail In: _____ **Phone:** _____

MEDICATIONS List medications you are currently taking.

Name	Dose	Directions

ALLERGIES to medications or substances.

IMMUNIZATIONS

Immunization	Year
Td (Tetanus, Diphtheria)	
Tdap (Tetanus, Diphtheria, Pertussis)	
Gardasil (HPV)	
Zoster (Shingles)	
MMR (Measles, Mumps, Rubella)	
Pneumococcal	
Meningococcal	
Hepatitis A	
Hepatitis B	
Influenza (Flu)	
Varicella (Chickenpox)	

SPECIALISTS

	Name	Phone #
Allergist		
Cardiologist		
Chiropractor		
Colorectal Surgeon		
Dermatologist		
Endocrinologist		
ENT		
Gastroenterologist		
Nephrologist		
Neuro Surgeon		
Neurologist		
Ob/Gyn		
Oncologist		
Opthamologist		
Optometrist		
Orthopedist		
Pain Management		
Podiatrist		
Pulmonologist		
Rheumatologist		

Acknowledgement of Receipt of
Notice of Privacy Practices and Requested Restrictions

By signing below, you acknowledge that you have received this Notice of Privacy Practices prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

I,_____have received a copy of this office's Notice of Privacy Practices.

Patient Name:_____Date of Birth: _____
(Please Print Name)

Patient/Legal Representative:_____Date: _____
(Signature)

If Legal Representative, relationship to Patient: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

And assign directly to **Nobles Internal Medicine** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Nobles Internal Medicine** for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare 'assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Signature of Insured/Guardian Date

E-Prescribing PBM Consent

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the drug benefitplan.
- **Medication history transactions** – Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent form, you are agreeing that Nobles Internal Medicine can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

_____ _____
Signature of Insured/Guardian Date

Consent Denied _____ _____
Date