John Pulliam M.D., PLLC
Spine and Nerve Surgery
(903) 957-3230 • 200 E. Evergreen St. Sherman, TX 75090
www.JohnPulliamMD.com • Fax: (903) 957-4046

New Patient Forms and Information

If you are able, please print off and complete the following forms before your visit. If your appointment is scheduled far in advance, we are happy to mail you a copy of the paperwork, and we also have plenty of copies available at the office. Completing—or at least reviewing—the forms at home will make it easier to lookup important information such as medications and medical history.

To help us accurately document you medical history and current medical problems, leading to the appropriate treatment of your condition, it is very important that you answer all portions of the New Patient Health History form.

MRI, X-ray, CT, and Myelogram Films

It is very important that you bring all recent (within ~ 2-3 years) radiological studies (e.g. x-rays, CT scans, MRIs, myelograms, etc.) with you to your visit. **Dr. Pulliam needs to see the actual images from the procedure: Either the printed films or, preferably, a CD, DVD, or other digital copy. The radiology report alone is not adequate for the previously mentioned studies.** If you had an EMG, bone density test, or bone scan, the radiology report alone is appropriate.

Please bring all relevant studies to your appointment, including the studies ordered by Dr. Pulliam's office. You will probably need to pick up the printed films or CD at the facility that performed the procedure, so be sure to contact them in advance and obtain the records before your appointment with Dr. Pulliam.

Your First Visit

Please arrive at your first appointment at least 15 minutes in advance of your scheduled appointment time. If you have not completed the new patient information forms, please allow extra time to do so at the clinic. Please bring the following with you to your first appointment:

- Completed new patient information packet,
- All recent radiology studies,
- Your driver license,
- Your health insurance card(s),
- A list of all current medications,
- And your copay or payment for the visit (we accept cash, check, Visa, Discover, and Mastercard).

We look forward to seeing you. Please do not hesitate to contact the office at 903-957-3230 if you have any questions.

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Patient Registration Form

Legal Name: _____ ☐ Mr. ☐ Mrs. ☐ Mrs. ☐_____ **Former Name:** _____

Last, First Middle

Birth Date: _____ **Sex:** ☐ Male ☐ Female **Social Security #:** _____

Month/Day/Year

Race: ☐ American Indian ☐ White ☐ Asian ☐ Pacific Islander ☐ Black

Ethnicity: ☐ Hispanic ☐ Not Hispanic

Marital Status: _____

Mailing Address: _____

No. & Street/PO Box City State Zip Code

Phone Numbers: _____ _____ **Email:** _____

Home Cell

Chose Dr. Pulliam because: ☐ Family ☐ Friend ☐ Close to home/work ☐ Hospital ☐ Insurance plan ☐ Phone book ☐ Internet ☐ Other:

Referred By: _____ **Pharmacy:** _____

Pharmacy Phone #: _____ **Pharmacy Address:** _____

Street City State

Insurance Information

Primary Insurance: _____ **Policy Number:** _____ **Group Number:** _____

Policy Holder: _____ **Birth Date:** _____ **Social Security #:** _____

Relationship to patient: _____ **Address:** _____

Phone: _____ **Occupation:** _____ **Employer:** _____

Secondary Insurance: _____ **Policy Number:** _____ **Group Number:** _____

Emergency Contact

Emergency Contact: _____ **Relationship to patient:** _____

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

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for my medical care and any amount that insurance does not cover. I authorize John Pulliam, MD, PLLC and my insurance company to release any information required to process my claims. I acknowledge that Dr. John Pulliam owns a minority interest of less than one percent of Baylor Scott & White Surgical Hospital at Sherman.

Patient/guardian signature: _____ **Date:** _____

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New Patient Health History

To help us provide you with the best medical care possible, please complete this entire form, which asks important questions about your current health and medical history. **Please write legibly.**

Name: _____ **Birth Date:** _____

Appointment Date: _____ **Sex:** ☐ Male ☐ Female

Referring Physician: _____

Primary Care Physician: _____

Injury, Illness Information

What is primary problem you are seeing the doctor about? _____

_____

How long have you had this problem? _____

How did the symptoms start? ☐ Suddenly ☐ Gradually Other: _____

Have you experienced similar problems in the past? _____

Is the problem related to: ☐ Vehicle accident ☐ Work Other: _____

What was the date of the injury or incident? _____

Radiology, Imaging, Neuro Studies

When was your most recent procedure for each item listed below? (Leave blank if not applicable.)

Procedure	Date	Procedure	Date
X-Rays:		Myelogram:	
CT:		Discogram:	
MRI:		EMG:	

Surgical History

If you've had any surgeries, please provide the approximate date of the procedure.

Surgery	Date(s)	Surgery	Date(s)
☐ Back Surgery:		☐ Hysterectomy:	
☐ Neck Surgery:		☐ Tubal Ligation:	
☐ Carpal Tunnel:		☐ C Section:	
☐ Ulnar Nerve:		☐ Thyroid Surgery:	
☐ Nerve Surgery:		☐ Mastectomy:	
☐ Appendix Removal:		☐ Stent:	
☐ Cataract:		☐ Pacemaker:	
☐ Colon Surgery:		☐ Knee Replacement:	
☐ Gall Bladder:		☐ Knee surgery, other:	
☐ Gastric Bypass:		☐ Tonsillectomy:	
☐ Hernia Repair:		☐ Coronary Artery Bypass:	
☐ Hip Replacement:		☐ Fracture Repair:	
☐ Shoulder surgery:		☐ **I've never had surgery.**	

☐ Other (describe): _____

☐ Other (describe): _____

Other Procedures

If applicable, provide the date of your most recent procedure and the provider for each item listed.

Procedure	Date	Name of Provider
☐ Spinal Injection:		
☐ Physical Therapy:		
☐ Chiropractic:		
☐ Pain Clinic:		

Allergies

Please list all medications you are allergic to:

Medication	Reaction (e.g. anaphylaxis, hives, rash, etc.)

Please list any other serious allergies you have (food, dermatologic, seasonal, etc.):

Allergen	Reaction

Are you allergic to any of the following?	☐Adhesive Tape ☐ Gadolinium/MRI Contrast ☐ CT Contrast/Kidney dye/Iodine ☐ Latex

Check here if you have no known allergies: ☐ **I have no known allergies.**

Medications

List all medications you are currently taking (or take as needed), including prescription, over-the-counter, herbal, and alternative medications; or, if applicable: ☐ I do not take any medications.

Medication	Dose	Frequency

You are welcome to provide a separate medication list.

Family History

(While completing this page, consider **only your *biological* relatives**.)

Please indicate if any of your family members have or had any of the following diseases:

	Mother	Father	Sibling(s)	Children
Alcoholism:	☐	☐	☐	☐
Aneurysm:	☐	☐	☐	☐
Asthma:	☐	☐	☐	☐
Bleeding disorder:	☐	☐	☐	☐
Cancer:	☐	☐	☐	☐
Depression:	☐	☐	☐	☐
Diabetes:	☐	☐	☐	☐
Heart disease:	☐	☐	☐	☐
Heart attack:	☐	☐	☐	☐
High blood pressure:	☐	☐	☐	☐
High cholesterol:	☐	☐	☐	☐
Kidney disease:	☐	☐	☐	☐
Migraine headaches:	☐	☐	☐	☐
Obesity:	☐	☐	☐	☐
Psychiatric disorder:	☐	☐	☐	☐
Seizure disorder:	☐	☐	☐	☐
Stroke:	☐	☐	☐	☐
Osteoporosis:	☐	☐	☐	☐
Other (describe):				
Other (describe):				
I am not able to provide information about this family member:	☐	☐	☐	☐

Any other family history: _____

Habits

Do you smoke? ☐Currently ☐ Never ☐Quit

How much per day? _____

When did you start? _____

When did you quit? _____

Do you use chewing tobacco? ☐Currently ☐ Never ☐Quit

How much per day? _____

When did you start? _____

When did you quit? _____

Do you drink alcohol daily? ☐Currently ☐ Never ☐Quit

Number of drinks per day: _____

Number of drinks per week: _____

Have you ever?

☐ Sought treatment for alcohol abuse?

☐ Used illegal drugs?

☐ Had an addition problem with narcotic pain medications?

Medical History

Please checkmark all diseases that you currently have or were previously diagnosed with.

☐ Seasonal allergies
☐ Angina (chest pain)
☐ Arthritis
☐ Asthma
☐ Atrial fibrillation
☐ Blood clots
☐ Emphysema/COPD
☐ Coronary artery disease
☐ Cancer (type): _____
☐ Crohn's disease
☐ Depression
☐ Anxiety
☐ Dementia
☐ Diabetes
☐ Gallbladder disease
☐ GERD (acid reflux)
☐ Hepatitis
☐ HIV/AIDS
☐ Hyperlipidemia
☐ High cholesterol
☐ High blood pressure
☐ Functional bowel disease (IBS)
☐ Cirrhosis, liver disease
☐ Migraine headaches
☐ Heart attack
☐ Osteoporosis
☐ Peptic ulcer disease
☐ Renal disease
☐ Seizures
☐ Stroke
☐ Substance abuse
☐ Thyroid disease
☐ Tuberculosis
☐ Bleeding disorder
☐ Heart failure, CHF
☐ Multiple sclerosis
☐ Parkinson's disease
☐ Peripheral neuropathy
☐ Other: _____

Additional Information: _____

Social History

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other: _____

Number of children: _____ **Do you live alone?** ☐ Yes ☐ No

Work Status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Disabled (date): _____
☐Retired (date): _____ ☐ Self-employed ☐ Other: _____

Employer: _____ **Job title, occupation:** _____

Review of Systems

Please indicate if you currently have or have recently had any of the following problems:

- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Double vision
- ☐ Blurry vision
- ☐ Visual loss
- ☐ Photophobia (light sensitivity)
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Difficulty swallowing
- ☐ Shortness of breath
- ☐ Coughing
- ☐ Wheezing
- ☐ Sleep apnea
- ☐ Chest pain
- ☐ Rapid heart beat
- ☐ Leg swelling
- ☐ Change in bowel movements
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Blood in stool
- ☐ Acid reflux
- ☐ Urinary Frequency
- ☐ Urinary Incontinence
- ☐ Urinary Retention
- ☐ Blood in urine
- ☐ Joint swelling
- ☐ Joint pain
- ☐ Back pain
- ☐ Neck pain
- ☐ Headache
- ☐ Dizziness
- ☐ Numbness
- ☐ Weakness, paralysis
- ☐ Seizure
- ☐ Anemia
- ☐ Bruise easily
- ☐ Blood clotting disorder
- ☐ Depression
- ☐ Memory loss
- ☐ Anxiety
- ☐ Skin rash
- ☐ Skin infection, MRSA
- ☐ Other: _____

Thank you.

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Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Summary

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. A current copy of our Notice of Privacy Practices is available on our website (http://www.JohnPulliamMD.com/privacypracticies.php).

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us by phone at (903) 957-3230 or mail at 200 E. Evergreen St., Sherman, TX 75090.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Which information to share with others
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We will **not** share your information for fundraising efforts or marketing purposes without your written consent, except for purposes consistent with state law, described in section "Marketing Uses of Your Information" of this notice (e.g. prescription drug discount program). We will **not** sell your information. We will **not** share any psychotherapy notes, unless required by law.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

State of Texas Privacy Notices

The Texas Medical Records Privacy Act and other state laws provide additional patient privacy protections.

Consumer Access to Electronic Health Records

If we are using an electronic health records system capable of fulfilling the request, we must, by the 15th business day after receiving a written request from you, provide your medical record in electronic form, unless you agree to accept the record in another form. We are not required to provide access to protected health information that is legally excepted from access, or to which access may be denied under state or federal law (e.g. 45 C.F.R. Section 164.524). **At this time, we do not have a records system capable of providing an electronic copy of your medical record to you.**

Marketing Uses of Your Information

We must obtain permission in writing from you to use or disclose your protected health information for any marketing purposes, unless the commutation is: face-to-face communication, a promotional gift of nominal value provided by us, necessary for administration of a patient assistance program or other prescription drug savings or discount program, or made at your oral request.

Sale of Protected Health Information

We will not sell your protected health information. We may share your information with other "covered" health care and insurance entities for the purposes of treatment, payment, health care operations, or other disclosures allowable by law.

Electronic Disclosure of Protected Health Information

We will not electronically disclose your protected information unless you authorize each and every disclosure; however, we may electronically share your information with other "covered" health care and insurance entities for the purposes of treatment, payment, health care operations, or other disclosures allowable by law without your authorization.

Charges for Information

We may charge a reasonable fee for copying billing or medical records, and we are not required to disclose or copy the records until the fee is paid unless there is a medical emergency.

Where to Find Additional Information

For more information, visit The Attorney General of Texas Consumer Protection Division webpage for State and Federal Health Privacy Laws: https://texasattorneygeneral.gov/cpd/state-and-federal-health-privacy-laws

Changes to the Terms of this Notice

This notice is effective on October 1, 2016. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

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Acknowledgement of Receipt of Privacy Practices

We are required by law to ask for written proof that you received our Notice of Privacy Practices. You are not required by law to sign this form.

- You cannot be denied treatment based on failure to sign this form, and refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.
- Signing does not mean that you have agreed to any special uses or disclosures (sharing) of your health records.
- Refusing to sign this acknowledgement does not prevent us from using or disclosing health information as HIPAA and state law permits.
- If you refuse to sign this acknowledgement, we must keep a record of this fact.

I have received a printed copy of the "Notice of Privacy Practices" for John Pulliam M.D., PLLC. Note that your signature below is only acknowledgement that you have <u>received</u> our "Notice of Privacy Practices."

Patient Printed Name: _____

Signature: _____ **Date:** _____

Parent/Guardian Printed Name: _____

Signature: _____ **Date:** _____