BEAVER
medical group

7541 US HWY 87 E, Suite #1
San Antonio, Texas 78263
(210) 648-9900

NEW PATIENT INFORMATION SHEET

WELCOME TO OUR PRACTICE!

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	DOB	SS#

ADDRESS	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	EMAIL

SEX (M,F)	RACE (CIRCLE ONE)	ETHNICITY (CIRCLE ONE)
	CAUCASIAN AFRICAN AMERICAN NATIVE AMERICAN ASIAN OTHER	HISPANIC OR LATINO NON HISPANIC OR LATINO OTHER

MARITAL STATUS (CIRCLE ONE)	LANGUAGE (CIRCLE ONE)
MARRIED DIVORCED SEPARATED WIDOWED SINGLE LONG TERM PARTNER	ENGLISH SPANISH FRENCH GERMAN JAPANESE MANDARIN OTHER

PATIENT'S EMPLOYER	EMPLOYER ADDRESS

BUSINESS PHONE	OCCUPATION	EMPLOYMENT STATUS (CIRCLE ONE)
		FULL-TIME PART-TIME RETIRED STUDENT

EMERGENCY CONTACT NAME	RELATIONSHIP	PHONE

HOW DID YOU HEAR ABOUT US?

FINANCIALLY RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

LAST NAME	FIRST NAME	MI	DOB	SS#

ADDRESS	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	RELATIONSHIP TO PATIENT

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	MEMBER #	GROUP#

PLEASE CIRCLE ONE : PPO POS HMO HRA HSA CHOICE PLUSE HEALTH SELECT OTHER

POLICY HOLDER NAME	DOB	RELATIONSHIP TO INSURED	SS#

SECONDARY INSURANCE NAME	MEMBER #	GROUP#

POLICY HOLDER NAME	DOB	RELATIONSHIP TO INSURED	SS#

PHARMACY INFORMATION

NAME	ADDRESS	PHONE

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Beaver Medical Group for all insurance benefits, otherwise payable by me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services renedered on my behalf or my dependent.

I authorize the above provider and/or any provider or supplier of services at Beaver Medical Group to release any information required for securing the payment of benefits.

I authorize the use of this signature for all insurance submissions.

SIGNATURE OF RESPONSIBLE PARTY	DATE

PERSONAL HISTORY	Have you ever had any of the following? (please check appropriate box)							
	YES	NO		YES	NO		YES	NO
HEART DISEASE			HIGH BLOOD PRESSURE			ASTHMA		
ARTHRITIS			KIDNEY/URINARY DISEASE			STROKE		
CANCER			MIGRAINES			HIGH CHOLESTEROL		
ANXIETY			DIABETES			DEPRESSION		
BLOOD DISORDERS			SEASONAL ALLERGIES			THYROID DISORDERS		

OTHER MEDICAL CONDITIONS (PLEASE LIST):

FAMILY HISTORY	Do any blood relatives have any of the following? (please check appropriate box)						
	YES	NO	WHICH RELATIVE?		YES	NO	WHICH RELATIVE?
HEART DISEASE				DIABETES			
HIGH BLOOD PRESSURE				ASTHMA/ALLERGIES			
HIGH CHOLESTEROL				STROKE			
ANXIETY/DEPRESSION				BLEEDING DISORDERS			
CANCER				THYROID DISORDERS			

OTHER MEDICAL CONDITIONS (PLEASE LIST):

SURGICAL HISTORY			IMMUNIZATIONS		ALLERGIES	
SURGERY	YEAR	PHYSICIAN	NAME	YEAR	ALLERGEN	REACTION
			FLU			
			TETANUS			
			PNUEMONIA			
			MENINGOCCAL			

SOCIAL HISTORY							HEALTH MAINTENANCE		
	YES	NO		YES	NO	HOW MUCH?	EXAM	YEAR	RESULTS
DO YOU SMOKE?			DID YOU EVER SMOKE?				COLONOSCOPY		
DO YOU DRINK ALCOHOL?			DID YOU EVER DRINK?				MAMMOGRAM		
DO YOU USE DRUGS?			DID YOU EVER USE DRUGS?				CHOLESTEROL		

MEDICATIONS (PLEASE INCLUDE ALL SUPPLEMENTS AND OTC)			FOR WOMEN ONLY	
NAME	STRENGTH	HOW OFTEN?	AGE AT ONSET OF MENSTRUAL CYCLE?	
			DATE OF LAST CYCLE?	
			ARE YOUR CYCLES REGULAR?	
			DATE OF LAST PAP SMEAR?	
			PREGNANCIES - HOW MANY?	
			NUMBER OF CHILDREN?	
			FOR MEN ONLY	
			DATE OF LAST TESTICULAR EXAM?	
			DATE OF LAST PROSTATE EXAM?	
			ANY URINARY DIFFICULTIES?	
PLEASE SEE RECEPTIONIST IF A LONGER FORM IS NEEDED			ANY ERECTILE DYSFUNCTION?	

PATIENT SIGNATURE	DATE

NOTICE OF PRIVACY

I have reviewed Beaver Medical Group's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document at no cost to me.

Patient requested copy: ☐ Yes ☐ No

Name of Patient Signature of Patient or Legal Guardian Relationship to Patient Date

FINANCIAL POLICY

I have reviewed Beaver Medical Group's Financial Policy, and I understand that the services I have elected to participate in implies a financial responsibility on my part**. I understand that as a courtesy, Beaver Medical Group will verify my coverage and bill my insurance on my behalf,** however I am ultimately responsible for payment of my bill and any fees not covered by insurance. I also understand that payment is due at the time of service.

I also understand that Beaver Medical Group requires me (as a patient) to have a credit card on file. For your protection this card will be kept on a secure HIPAA-compliant server which no personnel will have access to, (only the last 4 digits of your card will be viewable). This card will be used for patient balance after insurance adjudication and patient past due balances.

I certify that the information I have provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Beaver Medical Group, the full and entire amount of the bill incurred by me or the below named patient; or, if applicable any amount due after payment had been made by my insurance carrier.

Name of Patient Signature of Patient or Legal Guardian Relationship to Patient Date

AUTHORIZATION FOR RELEASE OF PRIVATE HEALTH INFORMATION (PHI)

***This gives the (representatives of Beaver Medical Group) the authorization to speak to your spouse, parent, child or significant other about your medical and/or financial information. Please DO NOT put N/A if you would like for us to be able to talk with someone other than yourself. This includes medication refills.**

I _____, date of birth _____, hereby authorization Beaver Medical Group to release my PHI to the following individual. This consent will remain in effect until Beaver Medical Group is otherwise notified by me in writing.

☐ Appointment Times ☐ Medical & Health Information ☐ Billing & Demographic Information ☐ All Information

Name of individual information may be released to Relationship to Patient

ADVANCED DIRECTIVES

Advance directives are legal documents that allow you to convey your decisions about end-of-life care ahead of time. They provide a way for you to communicate your wishes to family, friends and health care professionals. An Advance Directive tells how you feel about care intended to sustain life.

☐ I would like information regarding Advance Directives. ☐ I do not wish to have information provided to me at this time.

☐ I already have an Advance Directive. ☐ I do not have an Advance Directive

Name of Patient Signature of Patient or Legal Guardian Relationship to Patient Date

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMAION

Name of Patient (Please Print) Date

Signature of Patient or Legal Guardian Relationship to Patient

BEAVER MEDICAL GROUP POLICY'S

Beaver Medical Group PLLC would like to welcome you to our office. We appreciate the opportunity to serve you. The information below is provided FOR YOUR BENEFIT SO PLEASE READ, initial, sign and date.

_____ 1. **APPOINTMENT TIME:** We ask that our patients arrive 30 minutes prior to their appointment, this will allow our staff to update any paperwork or run tests that need to be completed before you see your provider. Patients arriving past their appointment time may need to be rescheduled. **Please note that we strictly enforce a ($25.00/ $50.00 No Show Fee), depending on the type of appointment. This charge will be enforced if you do not show up for your appointment or cancel 24 hours prior to your appointment. Multiple No Show appointments may be subject to dismissal from the practice.**

_____2. **CHANGE OF INFORMATION:** It is your responsibility to keep us informed on any changes to your personal information, (i.e. phone number, address, email address or power of attorney or insurance information).

_____ 3 **CREDIT CARD ON FILE/ PAYMENTS:** All applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of your appointment. We accept cash, checks, Visa, Mastercard, Discover or American Express. **Please be aware as of November 1, 2024, Beaver Medical Group requires all patients to keep a credit card on file. There will be a charge for all non-sufficient funds or returned checks which will be deducted from your credit card on file.**

_____ 4. **DRUG TESTING:** It is the policy of **Beaver Medical Group** that every new patient and/or anyone on a narcotic will be drug tested at the provider's discretion. Drug testing refusal will result in dismissal from the practice.

_____ 5. **INSURANCE VERIFICATION:** This office will make every effort to verify your insurance; however, if we are unable to verify your insurance you will be responsible for the balance due at the time of service. It is also your responsibility to notify us of any changes in your insurance **immediately.** Failure to notify us of any changes will result in the entire cost of services rendered being made payable by you at the time of your service.

_____ 6. **LAB RESULTS & TEST RESULTS:** Please allow 7–10 days for results. A member of our staff will contact you as soon as your results have been received and **YOUR PROVIDER HAS REVIEWED THEM.**
We are not a free-standing lab facility but as a courtesy to our patient we collect your lab specimens here in our office. **The convenience fee for this is $15.00.** If you do not want to pay the convenience fee, we will be happy to give you a requisition for your labs and you may utilize any facility of your choice.

_____7. **MEDICATION REFILL REQUESTS:** Please contact your pharmacy for any medication refills. The pharmacy will contact our office if they require any information from us to refill your medication. No refills will be processed after hours. Please request your medication refills 1 week prior to your running out. **Please allow 24 to 48 hours for your prescription refill to be processed.**

_____8. **NARCOTIC PAIN MEDICATION:** Our office will prescribe pain medication as needed for acute pain and only for a short period of time. If the patient suffers from chronic pain and needs further observation for possible long-term use of prescription narcotics, we will refer the patient to a pain management specialist. We will not prescribe narcotic pain medication and/ or controlled substances if we find that the patient is receiving them from multiple physicians and/or pharmacies. (**Every patient that we prescribe narcotic medication to must be evaluated by one of our provider's every 3 months for follow-up. Refills are subject to a drug test and at the provider's discretion.**

_____9. **REFERRALS TO SPECIALISTS:** Please allow our staff 7 -15 days to process your referral. **If you are unable to keep your scheduled appointment with your specialist, IT IS YOUR RESPONSIBILITY TO RESCHEDULE.** Please be advised that most referrals have an expiration date. If you cannot make your specialist appointment before the referral expires, there will be a charge for a repeat authorization.

I have read and agree with the above policies as set forth by Beaver Medical Group.

Patient Name _____ **Signature** _____ **Date** _____