WELCOME TO ADVANTAGE IR!

Our goal is to provide world class treatment and care for you. It all starts with getting to know you better, to make sure we provide the best possible care. We know it is a lot, but please fill out the information below as completely as possible.

I. Demographic Information

Patient Information			
Name:		SSN:	Marital Status:
Date of Birth:		Employer:	
Sex: ☐ Male ☐ Female		Height:	Weight:
Home Address:			
	City:	State:	Zip:
Phones	Home:	Mobile:	Work:
Permissions: ☐ Home ☐ Mobile ☐ Work		*I grant permission to have voice and/or text messages which may contain personal health information left on the phones selected.*	
Email Address: *By providing an email address, you allow Advantage IR in Texas (AIR Texas, PLLC) to contact you about your medical condition and potential future treatment advice via HIPAA compliant secure email.*			

Emergency Contact		
Contact Name:	Relation:	Phone
Release Records:	*I hereby authorize Advantage IR in Texas (AIR Texas, PLLC) to disclose my medical records including information regarding my condition, treatment, imaging, and diagnosis to my emergency contact.*	

Primary Insurance		
Insurance Carrier:	Plan #:	Group #:
Policy Holder Name: *(If different from patient)*	Date of Birth:	SSN:

Secondary Insurance *(If Applicable)*		
Insurance Carrier:	Plan #:	Group #:
Policy Holder Name: *(If different from patient)*	Date of Birth:	SSN:

II. Reason for Your Visit

III. Physician Information

Primary Care Physician		
Physician Name:		Location:
Phones	Office:	Fax:

Referring Physician *(If Different from Primary Care Physician)*		
Physician Name:		Location:
Phones	Office:	Fax:

Additional Physicians	
Physician Name 1:	Specialty:
Physician Name 2:	Specialty:

Release Records:	*I hereby authorize Advantage IR in Texas (AIR Texas, PLLC) to disclose my medical records including information regarding my condition, treatment, imaging, and diagnosis to the physicians listed above.*

IV. Medical and Medication History

Please list all operations you have had	
	Date:
	Date:
	Date:
	Date:
	Date:

Please list all active medical conditions	
	Duration:
	Duration:
	Duration:
	Duration:
	Duration:

Pharmacy
Pharmacy Name:
Location:

Please list all MEDICATIONS you take routinely *(including current and previous chemotherapy)*:

Name of Medication	*Dosage / Freq*		*Name of Medication*	*Dosage / Freq*

For the Items Below Check the Box if it Applies to You			
Constitutional (Health in General)			**Urinary and Reproductive**
Recent weight loss	☐	☐	Painful Urination
Recent weight gain	☐	☐	Difficult Urination
Fever	☐	☐	Frequent Urination
Eyes		☐	Pregnancy: 1 or more pregnancies
Corrected Vision (Glasses/Contacts)	☐		**Musculoskeletal (Muscles, Bones, Joints)**
Blurred Vision	☐	☐	Muscles weakness, pain/stiffness
ENMT (Ears, Nose, Mouth & Throat)		☐	Joint Pain
Hearing loss	☐	☐	Joint Stiffness
Use of hearing device	☐	☐	Back or Neck Pain
Snoring or sleep apnea	☐	☐	Cold extremities
Painful Swallowing	☐	☐	Difficulty Walking
Cardiovascular (Heart)		☐	Use of cane, walker, or wheelchair
Chest pain or angina	☐		**Skin**
Palpitations	☐	☐	Itching or Rash
High cholesterol	☐	☐	Sores or Lesions (Wounds)
Blood clots	☐		**Neurological**
Peripheral Vascular		☐	Lightheadedness or dizziness
Pain in Extremities / Legs	☐	☐	Weakness on one side
Cramping leg pain with activity	☐	☐	Numbness/ tingling on one side
Leg Swelling (or Ankles/Feet)	☐	☐	Frequent headaches
Skin changes on feet or legs	☐	☐	Seizures
Respiratory (Breathing)		☐	Difficulty controlling muscles
Shortness of breath	☐		**Psychiatric**
Difficulty breathing	☐	☐	Depression
Chronic or frequent coughs	☐	☐	Anxiety or nervousness
Wheezing or Asthma	☐		**Endocrine**
GI (Stomach & Intestines)		☐	Unexplained Weight Loss
Abdominal pain	☐	☐	Excessive Urination
Nausea	☐		**Hematologic/ Lymphatic (Blood and Lymph)**
Vomiting	☐	☐	Bleeding or bruising tendency
Change in stool pattern / bowel movements	☐	☐	Slow to heal after cuts
Diarrhea	☐	☐	Blood clots
Constipation	☐		
Bloody Stool / Bowel Movements	☐		

Medical Allergies
Are you ALLERGIC to any medicines, latex, X-Ray Dye, or Iodine? ☐ Yes ☐ No
If yes, please list allergies and reactions:

Immunization / Vaccinations	*Yes*	
Have you had an Influenza Immunization	☐	If so, when was your last shot?
If No, Why Not?		
Have you had a Pneumonia Vaccination	☐	If so, when was your last shot?

Social Use	*Yes*	
Do you smoke cigarettes or e-cigarettes (“vape”)?	☐	If so, how many packs/times a day?
At what age did you start?		If applicable, at what age did you stop?
Do you drink alcohol?	☐	If yes, how frequently daily/weekly?
At what age did you start?		If applicable, at what age did you stop?
Do you use recreational drugs?	☐	
If yes, types:		

VII. Advanced Medical Directive and Power of Attorney

Do you have an Advance Medical Directive?	☐ Yes ☐ No *(You Must Check One)*
If yes, Surrogate Decision Maker Name and Phone:	
Do you have a Healthcare Medical Power of Attorney	☐ Yes ☐ No *(You Must Check One)*
If yes, your Power of Attorney Name and Phone:	

VIII. Insurance and Payments

Financial Responsibility: Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurance carrier will be your responsibility, except as limited by our specific network agreement with your insurance carrier, if such an agreement is in place.

If you do not have health insurance, or if your health insurance will not pay for services rendered by us or if you notify us not to contact or bill your insurance company, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available at our front desk). Payment is due in full at the time of service.

By initialing this section, you acknowledge that you have received a copy of our Financial Policies to review. Available At: https://a-ir.link/EN-FIN-TX	Initial:

IX. Additional Notifications

Notice of Privacy Practice	
By initialing this section, I acknowledge that I have received a copy of the Notice of Privacy Practice which includes a Statement of Patient's Rights to review. Available At: https://a-ir.link/EN-NPP-TX	Initial:

Code of Conduct	
By initialing this section, I acknowledge that I have received a copy of the Code of Conduct Statement to review. Available At: https://a-ir.link/EN-COC-TX	Initial:

Use of Media	
By initialing this section, I acknowledge that I have received a copy of the Use of Media statement to review Available At: https://a-ir.link/EN-UOM-TX	Initial:

By signing below, I voluntarily consent to all medical and surgical treatment performed by Advantage IR in Texas (AIR Texas, PLLC) . I also consent to routine services, diagnostic procedures, medical treatment, other health care services deemed necessary by the health care providers treating me. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may cause injury or even death. I understand that I have a right to consent or to refuse to consent to any proposed surgery, procedure, or treatment, and to discuss it with my health care provider. I understand that if an employee or any individual associated with Advantage IR is exposed to my blood or bodily fluids, I will be tested for hepatitis viruses and the Human Immunodeficiency Virus (HIV).

The information on this form is accurate to the best of my knowledge.

Signature of Patient/Legally Authorized Representative _____ Date _____

Printed Name of Patient/Legally Authorized Representative _____ Relationship to Patient _____