FRANK E. MARTINEZ, MD
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CORPUS CHRISTI, TX 78414
Phone: 361-992-1600 Fax: 361-992-0176

NEW PATIENT DEMOGRAPHICS AND HISTORY

Full Legal Name _____ Nickname: _____

DOB: _____ Age: _____

Mailing Address: _____ State/Zip: _____

SSN: _____ Ethnicity: _____

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

Emergency Contact Name/Number/Relation: _____

Marital Status: _____ Name of Spouse: _____

Employer Name: _____ Occupation: _____

May we call you at work? _____ Best time to call you: _____

Preferred Pharmacy/Location: _____ Email: _____

Previous Primary Care Physician: _____

Do you have an advance directive/living will? If yes, provide copy.

List all other specialist that are treating you and the reason:

Tobacco Use: Caffeine Use: Alcohol Use Narcotic/illicit Drug Abuse/Use

Alcohol Use?	# per day:	Yrs:	Year Quit:
Tobacco Use?	# per day:	Yrs:	Year Quit:
Drug Use/Type?	# per day:	Yrs:	Year Quit:

FAMILY HISTORY

Are you Adopted? Yes No

Mother Alive (age) _____ Medical Conditions: _____

Father Alive (age) _____ Medical Conditions: _____

Brother(s) Alive (ages) _____ Medical Conditions: _____

Sister (s) Alive (ages) Medical Conditions:

Do you have children with heart problems? Please Explain:

CURRENT MEDICATIONS/VITAMINS/SUPPLEMENTS

DRUG STRENGTH/DOSE/HOW MANY TIMES A DAY/WHO PRESCRIBED:

ALLERGIES TO MEDICATION/FOOD/AIRBOURNE/X-ray CONTRAST?

SURGERIES AND PROCEDURES

Have you had cardiac catheterization? Yes No

Date:

Facility:

Was this intervention? Stent? Balloon? (circle one)

Have you had vascular surgery? Yes No

Date:

Facility:

Was this bypass graft? Angioplasty? Stent? (circle one)

Have you had heart surgery? Yes No

TYPE: _____

Date: _____

Facility: _____

Did you have difficulty during any of these procedures? _____

Other Surgeries: *Type/Date/Facility Surgeon*

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Females only: Have you had a total hysterectomy? Ovaries?

At age: Do you take birth control? Yes No

Have you gone through menopause? Yes No In the midst of:

~~Do you take hormone replacements? Yes No Type:~~

PERSONAL HISTORY AND RISK FACTORS

Have you been diagnosed with.....?

Diabetes: Yes No When: _____

High Cholesterol: Yes No When: _____

High Blood Pressure: Yes No When: _____

Blood flow problem limbs: Yes No When & which limb: _____

Venous or Arterial (circle one)

Heart Valve Disease: Yes No When & which valve: _____

Thyroid Disorder: Yes No When: _____

Bleeding tendencies: Yes No When & type: _____

Lung Disease: Yes No When: _____

Stroke Yes No When & which side: _____

Kidney problems Yes No When & type: _____

Heart Attack Yes No Age: _____

Are you currently experiencing any of the following symptoms? (please write yes or no on all that apply)

Cardiac/Vascular	
Chest pain or angina	Swelling of feet,ankles,hands
Palpitations	Leg pain with walking
Syncope (fainting)	Varicose Veins
Clamminess	Racing heart beat
Cardiac arrest	Waking at night short of breath
Constitutional	
Recent weight gain	Fatigue
Respiratory	
Chronic or Frequent Cough	Spitting up Blood
Shortness of breath on exertion	Shortness of breath at rest
Gastrointestinal	
Loss of appetite	Nausea or Vomiting
Blood in stool	Abdominal pain
Musculoskeletal	
Joint pain	Muscle weakness or pain
Skin/Derm	
Rash	Skin sores
Neurological	
Frequent Headaches	Lightheaded or Dizzy
Seizures	Stroke or TIA
Tremors	Memory Loss

Psychiatric	
Nervousness or anxiety	Depression
Difficulty Sleeping	Hallucinations
Genitourinary	
Blood in urine	Frequent urination
Painful or burning urination	
Hematologic Anemia	Bleeding or Bruising Tendency
HEENT	
Visual changes	Hearing loss

PATIENT SIGNATURE: _____ DATE: _____

Authorization and Consent

1. I request care from Frank B. Martinez, MD or one of their affiliates for treatment of my medical or mental health condition. This care may include medical tests, exams, or other treatments that are needed for my condition. I agree to this care.

Insurance and Payment Information:

Frank B. Martinez, MD receives payment for patient care from insurance companies, Medicare, and/or other third party programs.

1. I agree to have my insurance company, Medicare, or other third party payment program make payments directly to Frank B. Martinez, MD and/or its affiliates.
2. I agree to let my doctor(s) and/or the Frank B. Martinez, MD submit claims and required treatment information to my insurance company, Medicare, or other third party payment program for my care, and receive payments directly.
3. I understand that I must pay all charges, co-payments, and deductibles that are not covered by my insurance company, Medicare, or third party payment program.

Permission to Communicate with Your Primary Care Physician and/or Other Community Care Providers: In order to ensure continuity of care, it is often necessary to communicate information to your primary care physician, other community care providers and to your insurance company. These communications may include information about your medical treatment and mental health or substance abuse treatment. This information is limited to that which is necessary to the determination of coverage and the coordination of your care. Many insurance companies require us to document whether or not you will allow your clinician to communicate with your primary care physician and/or Health Insurance Company.

Signature of the patient (or person authorized to sign for patient):

_____ Date: _____

Relationship to Patient _____

Patient Consent Form

In April of 2003, new federal requirements regarding privacy of information for health care patients take effect. H.I.P.P.A., the Health Insurance Portability and Protection Act require that all medical providers, insurance companies and others put in place controls to ensure that your personal medical information is safe.

Frank E. Martinez, MD, and his Associates, requests that each patient sign this consent form; which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request the results of tests and procedures. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your test results released to family members you must sign this form. Signing this form will only give consent to release laboratory and radiology results to the family members indicated below? This consent form will not allow Frank E. Martinez, MD, and his Associates, to release any other information to these family members.

I authorize Frank E. Martinez, MD, and his Associates, to release my laboratory/radiology results and reports to the following individuals.

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____

Authorization to Leave Messages with Household Members/Answering Machine

From time to time it is necessary for representatives of Frank E. Martinez, MD, and his Associates, to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss lab or procedure results, or to ask a patient to call our office regarding an issue or concern. At no time will a representative of our office discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Name: _____ Date of birth: _____

Patient Signature: _____ Date: _____

Frank Martinez, M.D.

Financial Policy

I have received a copy, read, understand, and agree to Frank Martinez, M.D.'s Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to Frank Martinez, M.D., P.A..

I authorize Frank Martinez, M.D., P.A. to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Date: _____

Printed Name: _____

Signature: _____

Our Patient Payment Policy

Frank Martinez, M.D.

5920 Saratoga Blvd #320

Corpus Christi, Texas 78414

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

All patients must complete our *Patient Information Form. We believe that a good relationship is based on understanding and open communications. Our staff has been instructed to make every effort available to you to clarify any misunderstanding you have concerning your balance.*

For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with our Billing Specialist or the Practice Manager. Please refrain from asking the Doctor about your account as he is involved in your medical care and NOT the financial aspect of you care. Please direct all concerns to our billing specialist.

How May I Pay?

We accept payment by cash, check, VISA, and Mastercard. For your convenience, our billing office is staffed Monday through Thursday from 8:00 AM to 4:30 PM. The phone number is 361-992-1600 Ext 103.

You are expected to make payment in full upon receipt of a bill showing your balance due. Other payment plans or options may be available. Please contact our Patient Financial Services for this information and/or when your billing address changes. A monthly billing charge will be added to all accounts not paid in full within 45 days of service.

When is my account delinquent?

An account is considered past due 30 days following billing unless other arrangements have been made. Unpaid accounts beyond 90 days are considered delinquent and may be forwarded to our collection agency and will have a service fee/billing fee added.

How are my Medicine Refills handled?

Our policy is for the patient to call their pharmacy and ask them to fax the request for your medication to 361-992-0176 Attn: Refill Coordinator. Requests are usually handled within 48 business hours. Processing times may vary depending on the availability of your doctor, who for your safety must review each request prior to completion.

Are there Service Charges?

If the decision is made to see a patient who does not have his/her co-pay or deductible a service charge of $35 will be added.

Phone calls to Doctors

Our physicians will not be doing telephone medicine, if you need to talk your doctor we will give you an appointment. Calling the doctors after hours will result in a charge which insurances do not pay-making you responsible.

What about missed appointments?

We would appreciate your help and courtesy of a call if you are unable to keep an appointment. Please notify our office at least twenty-four(24) hours prior to the appointment time. We reserve the right to charge you a missed appointment fee of $30 and three (3) non cancelled missed appointments are grounds for patient discharge.

Legal Fees/Letter fees/Completion of forms

Any patient sent to collections will be responsible for all collection fees. If a patient is taken to small claims court the patient will be responsible for all fees/charges.

Any letter that you need from the Doctor, will carry a fee of $25.00 at the time of pickup.

Any forms that need to be completed: FMLA, Insurance Disability, Employment related etc will carry a $25.00 to be paid at the time it is picked up.

Assignment of Benefits

You need to assign benefits/payments for your insurance payments to the doctor.

Emergencies after hours

If you need medical care when the office is closed, please go to the ER of the closest Hospital to you.

If You Have...	You Are Responsible For...	Our Staff Will...
Commercial Insurance Also known as indemnity, "regular" insurance, or "80%/20% coverage."	Payment of the patient responsibility for all office visit, x-ray, injection, and other charges at the time of office visit.	Call your insurance company ahead of time to determine deductibles and coinsurance. File an insurance claim as a courtesy to you.
HMO & PPO plans with which we have a contract	If the services you receive are covered by the plan: All applicable co-pays and deductibles are requested at the time of the office visit.	Call your insurance company ahead of time to determine c deductibles, and non-covere services for you.

HMO with which we are not contracted.	Payment in full for office visits, x-ray, injections, and other charges at the time of office visit.	Provide the necessary informa for you to complete and file yo claim directly with the insuranc company.
Point of Service Plan or Out Of Network PPO	Payment of the patient responsibility- deductible, co-pay, non-covered services-at the time of the visit.	Call your insurance company ahead of time to determine out network benefits, co-pays, deductibles, and non-covered services. File an insurance claim on you behalf.
Medicare	If you have Regular Medicare, and have not met your $110 deductible, we ask that it be paid at the time of service. Any services not covered by Medicare are requested at the time of the visit. If you have regular Medicare as primary, and also have secondary insurance or Medicaid: No payment is necessary at the time of the visit. If you have regular Medicare as primary, but no secondary insurance: Payment of your 20% co-pay is requested at the time of the visit.	File the claim on your behalf, a well as any claims to your secondary insurance.
Medicare HMO	All applicable co-pays and deductibles at the time of the office visit.	File the claim on your behalf, a well as any claims to your secondary insurance.

If You Have...	You Are Responsible For...	Our Staff Will...
No Insurance	Payment in full at the time of the visit.	Work with you to settle your account. Please ask to speak w our staff if you need assistance

What if My Child Needs to See the Physician?

A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult (who consents to the treatment) is responsible for payment of the account, according to the policy outlined on the previous pages. We will not be involved in separation/divorce disputes.