TRINITY®
FAMILY MEDICINE CLINIC

PATIENT INFORMATION:

NAME (Nombre): _____

DATE OF BIRTH (Fecha de Nacimiento): _____

ADDRESS (Direccion): _____ CITY (Ciudad): _____

STATE(Estado): _____ ZIP(Codigo Postal):_____

TELEPHONE (HOME)(# Casa): _____ CELL(# Celular): _____

WORK(Numero de Trabajo): _____

SOCIAL SECURITY # (# Seguro Social)_____-____-_____ DRIVERS LICENSE #: _____ STATE: _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____ ZIP: _____ INJURY DATE: _____

MARITAL STATUS (circle) S M D W SEX: M / F

E-MAIL ADDRESS:_____

PATIENT PORTAL: May we contact you through our Patient Portal Website?: Yes__ No__

INSURANCE INFORMATION:

POLICY HOLDERS NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY #: ____-____-_____ DATE OF BIRTH _____ PHONE: _____

PRIMARY INSURANCE: _____ ID# _____ GROUP# _____

SECONDARY INSURANCE: _____ ID: _____ GROUP# _____

MEDICARE #_____ MEDICAID # _____

REFERRED BY:_____ TELEPHONE #:_____

PHARMACY INFORMATION:

NAME: _____ TELEPHONE #_____

EMERGENCY CONTACT INFORMATION:

Name of contact:_____

Address: _____ Phone#:_____

Relationship: _____ May we release medical information to this person? YES___ NO___

MEDICARE ASSIGNMENT FOR COVERED SERVICES

I CERTIFY THE INFORMATION GIVEN IN APPLYING FOR PAYMENT IS CORRECT AND REQUEST PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF.

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ASSIGNMENT OF INSURANCE BENEFITS

I HEREBY AUTHORIZE PAYMENT TO **JUAN P. VELAZQUEZ M.D.,** FOR MEDICAL SERVICES. I REPRESENT THAT I HAVE INSURANCE COVERAGE AND DO HEREBY AUTHORIZE **JUAN P. VELAZQUEZ M.D.,** TO RELEASE AND OBTAIN ALL INFORMATION NECESSARY TO SECURE PAYMENT OF SAID BENEFITS. IF MY INSURANCE FAILS TO PAY **JUAN P. VELAZQUEZ M.D.,** FOR ANY REASON I AGREE TO PAY ALL UNPAID BALANCES.

I HAVE READ AND UNDERSTAND MEDICAL SERVICES DISCLOSURE, MEDICARE ASSIGNMENT, AND ASSIGNMENT OF INSURANCE BENEFITS AND AGREE TO ALL TERMS STATED.

I ACKNOWLEDGE THAT THE NOTICE OF PRIVACY PRACTICES HAS BEEN MADE AVAILABLE TO ME IN THE LOBBY.

PAYMENT IS EXPECTED A THE TIME THAT OFFICE SERVICES ARE RENDERED. THANK YOU.

SIGNATURE: _____ **DATE:**_____

$25.00 No Show Fee

This fee applies to all patients private pay and/or insured.
Please call within 24hrs to cancel appointment.

Thank you

X_____

NEW PATIENT HISTORY
(age 4 and older)

NAME: _____
DATE: _____

PATIENT HISTORY
PLEASE CIRCLE ALL THAT APPLY

NASEL/SINUS ALLERGIES
ASTHMA
EMPHYSEMA (C O P D)
ECZEMA
RHEUMATOID ARTHRITIS
OSTEOARTHRITIS
DEEP VEIN BLOOD CLOTS
DIABETES
HYPOTHYROIDISM (low thyroid)
MIGRAINE
HIGH BLOOD PRESSURE
HEART ATTACK
HEART MURMMUR
CONGESTIVE HEART FAILURE
HIGH CHOLESTEROL
ALCOHOLISM
ANXIETY
DEPRESSION
STROKE
HIV/AIDS
EPILEPSY
URINARY INCONTINANCE
KIDNEY STONES
ERECTILE DYSFUNCTION
ABNORMAL PAP SMEAR
UTERINE FIBROIDS
ENDOMETRIOSIS
OVARIAN CYSTS
CANCER (list type): _____
NONE _____

OTHER CONDITIONS: (PLEASE LIST)
_____
_____

SURGICAL HISTORY
PLEASE CIRCLE ALL THAT APPLY

SKIN BIOPSY
CHOLECYSTECTOMY (GALLBLADDER)
HERNIA REPAIR
HYSTERECTOMY (UTERUS ONLY)
HYSTERECTOMY BSO (UTERUS AND OVARIES)
SPINAL SURGERY
BREAST BIOPSY
APPENDECTOMY
NONE _____
TUBAL LIGATION (TUBES TIED)
TONSILLECTOMY
TYMPANOSTOMY (EAR TUBES)
VASECTOMY
WISDOM TEETH
HEART BYPASS
CORONARY ARTER STENT
CESAREAN SECTION

OTHER: (PLEASE LIST) _____

IMMUNIZATION HISTORY
PLEASE LIST

TETANUS (Td or TDaP)	Year: _____	Don't know
HEPATITIS B (three shot series)	Year: _____	Don't know
MMR/MEASLES	Year: _____	Don't know
PNEUMONIA VACCINE (Pneumovax)	Year: _____	Don't know
HPV VACCINE (Guardasil)	Year: _____	Don't know
SHINGLES (Zostavax)	Year: _____	Don't know
TUBERCULOSIS (TB) TEST (PPD)	Year: _____	Don't know
HAVE YOU HAD CHICKENPOX?	Year: _____	Don't know

NEW PATIENT FAMILY HISTORY
(age 4 and older)

NAME: _____
DATE: _____

FAMILY HISTORY

PLEASE CIRCLE ALL THAT APPLY

ASTHMA	MOTHER	FATHER	BROTHER	SISTER	SON	DAUGHTER	OTHER: _____
DIABETES	MOTHER	FATHER	BROTHER	SISTER	SON	DAUGHTER	OTHER: _____
HEART ATTACK	MOTHER	FATHER	BROTHER	SISTER	SON	DAUGHTER	OTHER: _____
HIGH CHOLESTEROL	MOTHER	FATHER	BROTHER	SISTER	SON	DAUGHTER	OTHER: _____
HYPERTENSION	MOTHER	FATHER	BROTHER	SISTER	SON	DAUGHTER	OTHER: _____
STROKE	MOTHER	FATHER	BROTHER	SISTER	SON	DAUGHTER	OTHER: _____
DEPRESSION	MOTHER	FATHER	BROTHER	SISTER	SON	DAUGHTER	OTHER: _____
BREAST CANCER	MOTHER	FATHER	BROTHER	SISTER	SON	DAUGHTER	OTHER: _____
COLON CANCER	MOTHER	FATHER	BROTHER	SISTER	SON	DAUGHTER	OTHER: _____
MELANOMA	MOTHER	FATHER	BROTHER	SISTER	SON	DAUGHTER	OTHER: _____
OVARIAN CANCER	MOTHER	FATHER	BROTHER	SISTER	SON	DAUGHTER	OTHER: _____
PROSTATE CANCER	MOTHER	FATHER	BROTHER	SISTER	SON	DAUGHTER	OTHER: _____
OTHER CANCER	MOTHER	FATHER	BROTHER	SISTER	SON	DAUGHTER	OTHER: _____

OTHER CONDITIONS (PLEASE LIST):

_____

_____

MEDICATIONS CURRENTLY TAKING:

NAME	DOSE	NUMBER OF TIMES PER DAY
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

DO YOU TAKE ANY VITAMINS? YES NO

DO YOU TAKE ANY NATURAL SUPPLEMENTS? YES NO

ALLERGIES – CIRCLE ALL THAT YOU HAVE:

PENICILLIN NONE:
LATEX
SULFA OTHER:

TRINITY®
FAMILY MEDICINE CLINIC

REQUEST FOR MEDICAL RECORDS

Date: _____
Patient Name: _____
DOB: _____
SSN: _____

I _____ request that all records to be sent to the following physician.

Dr. Juan P. Velazquez, MD
6601 Blanco Rd Suite 100
San Antonio, TX 78216
Phone: (210) 541-0018
Fax: (210) 541-0024

If you have any questions please call our office during business hours: Monday thru Friday 8AM – 5PM. Thank you for your prompt attention.

Note: *If more than five pages, please mail to Address above.*
Please provide as much information, if possible, for the following:

Name of Physician/Clinic: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

SIGNATURE:

_____ _____
Patient or Parent/Guardian Date