First Physicians

East University Family Clinic
3051 East University
Odessa, Texas 79762
432/362-4376
Fax 432/362-6308

Wendover Family Medicine
4222 Wendover, Suite 600
Odessa, Texas 79762
432/552-5656
Fax 432/552-0992

Westview Medical Clinic
1220 West University
Odessa, Texas 79764-7118
432/332-6600
Fax 432/332-8011

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Alternative #: _____

Date of Birth: _____ Social Security #: _____

Driver's License #: _____ State Issued: _____

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Contact Name: _____

Please mark all that apply:

- ☐ Physical Examination
  - ☐ DOT
  - ☐ General
- ☐ Drug Screen
- ☐ Breath Alcohol
- ☐ Pulmonary Function Test/Spirometry
- ☐ Back X-Ray
- ☐ TB Test
- ☐ Other: _____

Acknowledgment of Receipt of Notice of Privacy Practices

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received.

Patient Name: _____ D.O.B.: _____

I, _____(printed name of patient or personal representative), acknowledge that First Physicians has provided a written copy of its Notice of Privacy Practices for Protected Health Information to:
Myself (or personal representative i.e.: parent/legal guardian)

And _____ (List the names of any other person you would want your information released to). You have the right to revoke this at any time.
Do you wish to release mental health information also? Yes or No

_____ _____
Signature of Patient or Personal Representative Date

_____ _____ _____
Printed Name Relationship to Patient Phone #

This notice will expire on _____

To be completed by First Physicians

We made a good faith attempt to provide the above named patient with a copy of our Notice of Privacy Practices for Protected Health Information, but we were not successful for the following reason:

_____

_____ _____
Signature of Employee Date

_____
Printed Name and Job Function

Health Questionnaire

Your Name:_____ Date of Birth: _____

Today's Date: _____ Last Doctor Seen: _____

Chief Complaint (describe briefly the problem which brings you to the doctor): _____

_____

_____

Prior Operations with Dates:_____

_____

Prior Medical Problems:_____

_____

_____

Current Medications:_____

_____

Drug Allergies: [] None _____ please initial the blank

[] Listed as follows: _____

_____

Family History (please provide any history of family health problems which may be significant):_____

_____

_____

_____

Social History: [] Never smoked [] Quit smoking as of _____ [] Still smoke

If you smoked or still smoke, how much?_____

How much alcohol do you consume in an average week?_____

I hereby authorize East University Family Medicine to render any and all necessary treatment to me.

Signature _____ Date _____