Lomibao
RHEUMATOLOGY & WELLNESS CARE

Patient Information

Last_____ First_____ M_____

DOB_____/_____/_____ Sex circle one: Female Male SS#_____-_____-_____

Cell Phone_____ Home Phone ☐ check here if same as cell_____

Email_____

Address_____
Street City State Zip

Emergency/Alternate Contact

Last_____ First_____ M_____

Relation_____ Phone_____ Email_____

Employer ☐ check here if not employed

Name_____ Phone_____

Address_____
Street City State Zip

Primary Insurance

Name_____ Phone_____

Group_____ ID_____

Address_____
Street City State Zip

Primary Insured ☐ check here if same as patient

Last_____ First_____ M_____

DOB_____/_____/_____ Relationship to Patient_____

Phone_____ Email_____

Address_____
Street City State Zip

Secondary Insurance ☐ check here if none

Name_____ Phone_____

Group_____ ID_____

Address_____
Street City State Zip

7700 Lakeview Pkwy Suite 300A
Rowlett, TX 75088
Phone: 469-825-4010
Fax: 469-825-4020

Last_____ First_____ DOB_____/_____/_____

Secondary Insured ☐ check here if same as patient ☐ check here if same as primary insured

Last_____ First_____ M_____

DOB_____/_____/_____ Relationship to Patient_____

Phone_____ Email_____

Address_____
Street City State Zip

Referring Provider

Last_____ First_____

Phone_____ Fax_____

Address_____
Street City State Zip

Primary Care Provider ☐ check here if same as referring provider

Last_____ First_____

Phone_____ Fax_____

Address_____
Street City State Zip

Pharmacy - Local

Name_____ Phone_____ Fax_____

Address_____
Street City State Zip

Pharmacy - Mail Order ☐ check here if none

Name_____ Phone_____ Fax_____

Address_____
Street City State Zip

Demographics - Please circle one of each of the following:

| Marital Status | Race | Ethnicity | Language |
|---|---|---|---|
| Annulled | American Indian/Alaskan Native | Declined to specify | English |
| Divorced | Asian | Hispanic or Latino | Other |
| Domestic Partner | Black or African-American | Not Hispanic or Latino | Spanish |
| Legally Separated | Declined to specify | Other | |
| Married | Multiracial more than one race | | |
| Single | Native Hawaiian or Other Pacific Islander | | |
| Widowed | White | | |

Last_____ First_____ DOB_____/_____/_____

## Patient Preference Regarding Communication of Personal Health Information

I hereby grant permission for Lomibao Rheumatology & Wellness Care, PLLC to disclose and discuss any information related to my medical condition(s) with the following individual(s), if requested by said individual(s):

Last_____ First_____

Relation_____ Phone_____

Last_____ First_____

Relation_____ Phone_____

Last_____ First_____

Relation_____ Phone_____

Last_____ First_____

Relation_____ Phone_____

Last_____ First_____

Relation_____ Phone_____

☐ I do not wish to grant permission for any individual(s) to have access to any information regarding my medical condition(s).

Last_____ First_____ DOB_____/_____/_____

## ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received, reviewed, and understand the HIPAA Notice of Privacy Practices ("HIPAA Notice") on behalf of the Lomibao Rheumatology & Wellness Care, PLLC. I acknowledge that the HIPAA Notice describes Lomibao Rheumatology & Wellness Care, PLLC's policies and procedures regarding the use and disclosure of my protected health information created, received, transmitted, and maintained by the Lomibao Rheumatology & Wellness Care, PLLC.

In addition, by signing below, I acknowledge and agree to authorize the Lomibao Rheumatology & Wellness Care, PLLC to communicate the Notice via e-mail and my health information through the use of phone, voicemail, e-mail, text message, electronic communications, telehealth technology, and personal communication as well as including electronic communication for announcements, newsletters, or other similar purposes as permitted under applicable law. I am hereby informed that this notice is downloadable on the company website and will be posted to my online portal.

_____ _____

**Patient Signature** **Date**

## ACKNOWLEDGEMENT OF RECEIPT OF TEXAS MEDICAL BOARD NOTICE

By signing below, I hereby acknowledge that I have received, reviewed, and understand the Texas Medical Board ("TMB Notice") on behalf of the Lomibao Rheumatology & Wellness Care, PLLC. I am hereby informed that this notice is downloadable on the company website and will be posted to my online portal.

_____ _____

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Last_____ First_____ DOB_____/_____/_____

## ACKNOWLEDGEMENT OF RECEIPT OF Financial Policy, Billing Procedures, Card on File Policy

By signing below, I hereby acknowledge that I have received, reviewed, understand and agree to the Financial Policy, Billing Procedures, Card on File Policy of Lomibao Rheumatology & Wellness Care, PLLC. I am hereby informed that this notice is downloadable on the company website and will be posted to my online portal.

_____ _____

**Patient Signature** **Date**

## ACKNOWLEDGEMENT OF RECEIPT OF Appointment Confirmation Policies

By signing below, I hereby acknowledge that I have received, reviewed, understand and agree to all of the Appointment Confirmation Policies of Lomibao Rheumatology & Wellness Care, PLLC. I am hereby informed that this notice is downloadable on the company website and will be posted to my online portal.

_____ _____

**Patient Signature** **Date**

## ACKNOWLEDGEMENT OF RECEIPT OF Forms & Medical Records Copies Policies

By signing below, I hereby acknowledge that I have received, reviewed, understand and agree to all of the Forms & Medical Records Copies Policies of Lomibao Rheumatology & Wellness Care, PLLC. I am hereby informed that this notice is downloadable on the company website and will be posted to my online portal.

_____ _____

**Patient Signature** **Date**

## ACKNOWLEDGEMENT OF RECEIPT OF Medication Refill & Controlled Substance/Psychoactive Drugs Policies

By signing below, I hereby acknowledge that I have received, reviewed, understand and agree to the Medication Refill & Controlled Substance/Psychoactive Drugs Policy of Lomibao Rheumatology & Wellness Care, PLLC. I am hereby informed that this notice is downloadable on the company website and will be posted to my online portal.

_____ _____

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Last_____ First_____ DOB_____/_____/_____

## Consent to Receive Medical Care

I hereby authorize Lomibao Rheumatology & Wellness Care, PLLC and any employee working under direction of the physician to provide medical care for me. This medical care may include services and supplies related to my health and may include but not limited to preventive, diagnostic, therapeutic, rehabilitative, maintenance, counseling, assessment or review of physical or mental status/function of the body. This consent includes contact and discussion with other health care professionals for care and treatment.

_____ _____

**Patient Signature** **Date**

## Consent for Telemedicine

1. I hereby authorize Lomibao Rheumatology & Wellness Care, PLLC to use the telehealth practice platform for telecommunication for evaluating, testing and diagnosing my medical condition(s).

2. I understand that it is my responsibility to set up and learn how to use the telehealth system *prior* to my scheduled appointment time.

3. I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended.

4. I accept that the professionals intend to offer the telehealth sessions with video call; however, I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed cannot be met.

5. I understand that my current insurance may not cover the fees for telehealth practices and I may be responsible for any fee that my insurance company does not cover for this service.

_____ _____

**Patient Signature** **Date**

☐ check here if declines telemedicine

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Last_____ First_____ DOB_____/_____/_____

## ACKNOWLEDGEMENT OF RECEIPT OF COVID-19 Risk Patient Informed Consent

By signing below, I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment visit, and I give express consent for my Lomibao Rheumatology & Wellness Care, PLLC provider and staff at this location to proceed with treating me. I am hereby informed that this notice is downloadable on the company website and will be posted to my online portal.

I represent that I have been practicing all current CDC guidelines with respect to “social distancing,” and, to my knowledge, I neither have symptoms of COVID-19, have COVID-19, nor have I been in contact with a person who has tested positive for, or who is suspected to be positive for, COVID-19.

By signing below, I hereby acknowledge and represent that I have: (i) been informed by Lomibao Rheumatology & Wellness Care, PLLC of its desire to protect its patients, staff, and the community at large; and (ii) been given the option to defer my treatment to a later date.

_____ _____

**Patient Signature** **Date**

## CDC Notice COVID-19 Screening

| | | |
|---|---|---|
| 1. Have you experienced any of the following symptoms in the past 48 hours: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea? | **YES** | **NO** |
| 2. Within the past 14 days, have you been in close physical contact (6 feet or closer for at least 15 minutes) with a person who is known to have laboratory-confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19? | **YES** | **NO** |
| 3. Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19? | **YES** | **NO** |
| 4. Are you currently waiting on the results of a COVID-19 test? | **YES** | **NO** |

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## Clinical History Intake

How did you hear about us?

What is your Reason for Referral?

What is the History of your Present Illness? (ie. onset, location, duration, characteristics, aggravating or alleviating factors, treatments attempted)

Please log into the **Patient Portal** ( **http://www.nextmd.com** ) to:

1. Enter your past clinical histories (ie. medical, surgical, family, social)
2. Fill out the multi-dimensional health assessment questionnaire (MDHAQ)

If you do not yet have a username and password, call the office at 469-825-4010 to receive an email with Patient Portal account set up information.

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Last_____ First_____ DOB_____/_____/_____

Medications - please list both prescription & over-the-counter ☐ check here if not taking any medications

| Name | Dose | Frequency | When started taking |
|---|---|---|---|

Allergies - tell us what type of reaction happens Others:

☐ check here if no known drug allergies

- ☐ Amoxicillin
- ☐ Aspirin
- ☐ Erythromycin
- ☐ Ibuprofen
- ☐ Insulin
- ☐ Penicillin
- ☐ Sulfa

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Review of Systems - Please circle if you are ***currently*** experiencing any of the following.
If you are not experiencing any of these, please circle None in each category.

| Constitutional | Cardiovascular | Metabolic/endocrine | Skin |
|---|---|---|---|
| None | None | None | None |
| Chills | Chest pain | Cold intolerance | Discoid rash |
| Fatigue | Palpitations | Hair loss | Nail changes |
| Night sweats | Raynaud's | Heat intolerance | Extreme sun sensitivity |
| Weight gain | | | Psoriasis |
| Weight loss | Gastrointestinal | Neurological | |
| | None | None | Musculoskeletal |
| HEENT | Abdominal pain | Confusion | None |
| None | Bloody stools | Extremity numbness | Height loss |
| Vision loss | Constipation | Headache | Joint pain |
| Blurred vision | Diarrhea | Memory loss | Joint swelling |
| Dental decay | Difficulty swallowing | Seizures | Joint tenderness |
| Dry mouth | Heartburn | Fainting | Low back pain |
| Dry eyes | Nausea | Stroke | Morning stiffness |
| Nose bleeds | Vomiting | | Muscle cramping |
| Hearing loss | | Psychiatric | Muscle weakness |
| Nasal sores | Genitourinary | None | Neck pain |
| Oral ulcers | None | Anxiety | |
| Red eye | Painful urination | Depression | Hematologic/lymph |
| Sinusitis | Bloody urine | Emotionally labile | None |
| | Urinary frequency | Hallucinations | Easy bleeding |
| Respiratory | | Insomnia | Easy bruising |
| None | | | Blood clots |
| Cough | | Immunologic | |
| Bloody cough | | None | |
| Pleurisy | | Allergic rhinitis | |
| Shortness of breath | | Frequent infections | |
| | | Food allergies | |

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