



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:

<u>Marital Status</u>	<u>Race</u>	<u>Ethnicity</u>	<u>Language</u>
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		

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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).

ACKNOWLEDGEMENT OF RECEIPT OF Emergency Room Disclaimer

For medical urgent situations and emergencies we advise you to go to the nearest emergency room or to call 911. There is no overnight, weekend, holiday call coverage, and there is no call coverage whenever the office is closed for other reasons. PLEASE REPORT TO THE NEAREST EMERGENCY ROOM.

Patient Signature

Date

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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.

Patient Signature

Date

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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.

Patient Signature

Date

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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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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

<input type="checkbox"/> Amoxicillin	<input type="checkbox"/> Insulin
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Ibuprofen	

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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.

<u>Constitutional</u>	<u>Cardiovascular</u>	<u>Metabolic/endocrine</u>	<u>Skin</u>
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	<u>Gastrointestinal</u>	<u>Neurological</u>	
	None	None	<u>Musculoskeletal</u>
<u>HEENT</u>	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		<u>Psychiatric</u>	Muscle weakness
Nasal sores	<u>Genitourinary</u>	None	Neck pain
Oral ulcers	None	Anxiety	
Red eye	Painful urination	Depression	<u>Hematologic/lymph</u>
Sinusitis	Bloody urine	Emotionally labile	None
	Urinary frequency	Hallucinations	Easy bleeding
<u>Respiratory</u>		Insomnia	Easy bruising
None			Blood clots
Cough		<u>Immunologic</u>	
Bloody cough		None	
Pleurisy		Allergic rhinitis	
Shortness of breath		Frequent infections	
		Food allergies	

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