NORTH TEXAS ID CONSULTANTS

Personal Information

Your Name: _____ Birthdate: _____ Date: _____

Address: _____ Apt: _____ City: _____ State: _____ Zip: _____

Email: _____ Ethnicity: ❑Latino/Hispanic ❑ Non Latino/Hispanic

Home Phone: _____ Race: _____

Fax: _____ Work Phone: _____ Cell Phone: _____

Best way to reach you: Work Cell Email

Referring Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician _____ Phone: _____

Spouse: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ hm / cell / wk

*EmergencyContact _____ Relation: _____ Phone: _____ hm /cell / wk

Patient's Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Please email this information to: vaccine.study@ntidc.org

Screening

Vaccine Study

DOB: _____ Patient : _____ Date: _____

Have you recieved any vaccines in the last 60 days?	
Vaccine & date:	
Vaccine & date:	
Vaccine & date:	

I have read the consent regarding contraception and understand that whether male or female, I must use an acceptable method of contraception during the study and for 28 days after the last dose of study intervention.

initials _____ date _____

Medical Issues (Please include date started)

Ear/Nose/Throat: _____

Cardiovascular: _____

Respiratory: _____

Gastrointestinal: _____

Neuro/Muscular: _____

Skin: _____

Urinary: _____

Psych/Soc: _____

Other: _____

_____

_____

_____

_____

Required: height: _____ weight:_____

North Texas Infectious Diseases Consultants, PA.

Consent for Treatment

I, as a patient/legal guardian, do consent for medical treatment by North Texas Infectious Diseases Consultants' (NTIDC) physicians and physician assistants, this is inclusive of any treatment or procedure they deem medically necessary.

Authorization to Release Medical Information

This is to serve as authorization to release medical information compiled in the course of medical treatment at NTIDC to the undersigned patient. A copy of this will serve as an original.

Acknowledgement of Receiving and Reading a Copy of, "Notice of Privacy Practices" and "Patient Rights and Responsibilities"

I acknowledge receipt of NTIDC's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how NTIDC may use and disclose by confidential information. I understand that NTIDC reserves the right to change their privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be made available to me upon request.

Tardy and Late Cancellation Policy

In order to best serve all of our patients it may be necessary to reschedule your appointment if you are 15 minutes late or more. Failure to come in for your appointment without giving our office at least 24 hours notice may result in a $30 charge on your account.

Physician Assistant Consent for Treatment

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care. "Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

I understand that at any time I can refuse to see the physician assistant and request to see a physician.

I have read the information above and consent to all.

Print Patient Name **Date of Birth** **Patient's Signature** **Date**

NORTH TEXAS INFECTIOUS DISEASES CONSULTANTS, PA **Patient**
Consent for Use and Disclosure of Protected Health Information

North Texas Infectious Diseases Consultants, PA, (NTIDC) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to NTIDC's Notice of Privacy Practice for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Procedures prior to signing the consent. NTIDC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the NTIDC Privacy Officer at 3409 Worth St, Suite 710, Dallas, Texas, 75246.

You may disclose protected health information (PHI) about me to the people listed below. (You must include full name.)

1._____ 2._____ 3. _____

With my consent, NTIDC may email me, any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that NTIDC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement

Email Address:_____ **N/A**

This office usues LabCorp. If your insurance requires that you use a different lab you must let the office know. My insurance prefers: (circle one)
LabCorp Quest Unknown (If unknown you must call your insurance to check)

With my consent, NTIDC may contact me regarding a possible research study.

Initials_____

How did you hear about us? _____

By signing this form, I consent to NTIDC's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance to prior consent.

_____ _____
Print Patient's Name Date of Birth Patient's Signature Date

_____ _____
Signature of Patient's Legal Guardian Print Name of Patient's Legal Guardian

Medication List

Name:_____ DOB:_____

Allergies (please include reaction:)_____

_____

_____

Drug Name	Dose	Route	Frequency	Date Started

Signature:_____Date:_____

(Office Only) Reviewed by:_____Date:_____

Please Complete and Return with Paperwork:

List of comorbidities that are or might be associated with an increased risk of progression to severe COVID-19

Please check if you have the following moderate to severe illness

____Asthma

____chronic obstructive pulmonary disease (COPD)

____emphysema

____chronic bronchitis

____idiopathic pulmonary fibrosis and cystic fibrosis

____diabetes (including type 1, type 2, or gestational)

____heart failure, coronary artery disease

____congenital heart disease

____cardiomyopathies

____pulmonary hypertension

____moderate to severe high blood pressure

____obesity (body mass index [BMI] ≥30 kg/m^2) (google BMI calculator for help)

____chronic liver disease

____cirrhosis

____sickle cell disease

____thalassemia

____cerebrovascular disease

____neurologic conditions (dementia)

____end stage renal disease

____organ transplantation

____cancer

____uncontrolled HIV infection

____other immunodeficiencies

____hepatitis B infection

____sleep apnea

____Parkinson's disease

____Seizures

____ischemic strokes

____Intracranial hemorrhage

____Guillain-Barré syndrome

____Encephalopathy

____Meningoencephalitis

____Live in nursing homes

____ Live in long-term care facilities.

If you take medications for any illness you have checked please list below with start date.

Medication	Dose	Frequency	Date started
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____