Please read and complete the following paperwork prior to your appointment at The Block Center

Please select the appropriate history form as well. The child's form is for age birth to 18 years of age. The adult form is for over 18 years old.

The Block Center
PROVIDER NOTICE
OF INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and disclosures of health information

We seek your consent to use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. You can revoke your consent.

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact The Block Center.

Individual rights

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you $25.00(twenty five dollars) for the first twenty pages, $0.50 (50 cents) for each page thereafter, and $9.40 to mail certified with return receipt. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact The Block Center You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our legal duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact:
The Block Center
5913 Lovell Avenue, Suite A,
Fort Worth, TX 76107
Phone: (817) 280-9933

I hereby declare that I have received and read the copy of The Block Center's Provider Notice of Information Practices.

Patient's printed name_____

Signature of patient or parent (if minor child) _____

Date_____

The Block Center
5913 Lovell Avenue, Suite A, Fort Worth, TX 76107
817-280-9933

IT IS IMPORTANT THAT YOU OR ANYONE COMING WITH YOU NOT WEAR ANY PERFUME, COLOGNE, AFTERSHAVE OR FRAGRANCES OF ANY KIND TO THE OFFICE. THIS ALSO INCLUDES TOBACCO ODORS, SHAMPOO, HAIR SPRAY AND FABRIC SOFTENER WITH FRAGRANCE. DUE TO THE SENSITIVITIES OF DR. BLOCK AND OTHERS IN OFFICE, YOU WILL BE UNABLE TO ENTER THE OFFICE IF YOU ARE WEARING ANY FRAGRANCE. IF YOU DO COME TO THE OFFICE WITH ANY FRAGRANCE ON, ARRIVE MORE THAN 15 MINUTES LATE OR DO NOT HAVE YOUR PAPERWORK FILLED OUT COMPLETELY, YOU WILL BE REQUIRED TO RESCHEDULE YOUR APPOINTMENT AND FORFEIT YOUR DEPOSIT.

Payment is due at the time service are rendered and is payable by cash, check, MasterCard, or Visa.

We require 24 hours notice for rescheduling appointments. If you have any questions about your appointment please call during office hours so that we may clarify them prior to your visit.

We look forward to your visit.

I understand that The Block Center does not accept insurance for payment and that I am responsible for payment of all of my medical care. I understand that payment is due at the time of service.

If you will be filing claims with your insurance company you will need to sign an authorization to release information. Many times your insurance company will request more information from our office before they will process your claim. Please fill out the attached authorization with your insurance information. Without this signed consent we will be unable to release the information and your claim will not be processed. If your insurance company requests copies of your medical records, you will be billed for the cost of making the copies and mailing them to the insurance company. The charge approved by the State of Texas for this service is $25.00 for the first 20 pages and $0.50 for each page thereafter. There will also be fees for mailing the records. These fees include a certified fee, a returned receipt fee and the postage fee. These fees vary in price depending upon how much the copies weigh and the location or 'zone' they are being mailed to. We mail all medical records certified, return receipt so that we have proof that your insurance company did in fact receive your records.

Please initial below:

_____ I agree to have the Block Center mail copies of my medical records to my insurance company and I agree to pay the fees as outlined above each time my insurance company requests copies of my medical records.

_____ I do not want The Block Center to send copies of my medical records to my insurance company.

_____ _____
Signature of Patient or Responsible Party Date

The Block Center
5913 Lovell Avenue, Suite A, Fort Worth, TX 76107
817-280-9933

PATIENT RECORD OF DISCLOSURE

In general the HIPPA privacy rule gives patients the right to request on uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. This information will remain in effect until revoked in writing.

I wish to be contacted in the following manner (check all that apply):

- □ **Home/Cell Telephone** _____
- □ **O.K. to leave message with detailed information**
- □ **Leave name/doctor with call back number only**
- □ **Work number**_____
- □ **Leave detailed message on work voice mail**
- □ **Leave name/doctor with call back number only**
- □ **When unable to contact me by phone, a written communication may be sent to my home address**
- □ **Other**_____

_____ _____
Print name of patient Birth Date

_____ _____
Signature of patient or guardian Date

Healthcare providers must keep records of PHI disclosures.

Medicaid Release Information

I,_____,
(Patient or parent/guardian of patient) understand that Dr. Mary Ann Block is not a Medicaid provider. I understand that my relationship with The Block Center is based on private pay and that I am responsible for all fees related to medical care. I understand that these fees are due at the time of service. I understand that no Medicaid claims will be or can be filed on my behalf for any services at The Block Center.

_____ _____
(Signature of patient or parent/guardian of patient) Date

New Patient Personal Information Sheet

Personal Information: Date_____

_____ _____ ____/____/_____ _____ _____ _____

Patient's Full Legal Name | Sex | Birth Date | Race | Age | Marital Status

_____ _____ _____

Patient's Social Security No. | Patient's Driver's License No. | Spouse's Name

_____

Patient's Permanent Street Address | City/State | Zip Code

_____ _____ _____

Home Phone No. | Cell Phone No. | E-Mail Address

I give permission for The Block Center to send me information and updates. I understand that if I receive emails from The Block Center that I cannot contact The Block Center through this email address. It is for information sent to me only.

_____ _____

Signature | Date

Financial Information:

_____

Responsible Party Name (First) (Middle) (Last) | Telephone No./Ext

_____ _____ _____

Social Security No. | Work No. | Driver's License No.

Please check the payment method you will be paying for your services:

( ) Cash ( ) Check ( ) Visa ( ) Master Card

Credit card number for **phone appointments** or **supplement orders**

_____Exp date_____Security Code_____

IN CASE OF EMERGENCY, NOTIFY:

_____ _____

Name | Phone Number

_____

Email address

Adult History Form
Mary Ann Block, DO, PA
5913 Lovell Avenue, Suite A, Fort Worth, TX 76107
817-280-9933

Today's Date_____

This questionnaire is to help me evaluate your symptoms. This history is the single most important source of information about you. It is estimated that 70% of health problems can be solved from the history, 20% from the physical exam and 10% from lab and X-rays.

General Information

Name_____Date of birth_____

Address_____(City)_____(State)_____(Zip)_____

Phone(_____)_____ Age_____

Marital Status_____Single_____Married_____Divorced_____Separated_____Widow/Widower

Occupation_____Hobbies_____

Work History and Dates _____

_____

_____

_____

Education: Years of High School _____ Years of College _____ Years of Post-graduate_____

List other countries where you have lived_____

List out of country travel_____

1. How did you hear about The Block Center?_____
2. Name of primary care physician_____
3. Describer problems which prompted you to call The Block Center:

_____ _____

_____ _____

_____ _____

4. Have you tried other professionals for this complaint?_____If Yes, explain_____

_____

5.Has child had any treatment for this problem?_____If Yes, explain_____

_____

6. What do you wish to accomplish?_____

_____

General Health Information

When and where was last physical exam? _____

List all prescription medications, over-the-counter medications and supplements currently taking:

Name	Dose	Frequency	How Long Taking
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

Have you taken antibiotics or steroids in the past year?_____Yes_____No

Do you take herbs?_____Yes_____No Do you now or ever, used tobacco in any form?_____Yes_____No

Do you currently use tobacco?_____Yes_____No What kind?_____How much?_____

Do you currently drink alcohol?_____Yes_____No, If yes, how often?_____How much?_____

Do you currently use street drugs?_____Yes_____No If yes, how often?_____How much?_____

List any allergy to drugs with symptoms:

Drug	Symptom	Drug	Symptom

Check which applied to you when you were a child:

____Bothered by foods	____Poor Appetite	____Bottle Fed	____Behavior Problems
____Eczema	____Constipation	____Stomachaches	____Feeding Problems
____Headaches	____Hyperactivity	____Night Sweats	____Failure to Thrive
____Learning Problems	____Dyslexia	____Bedwetting	____Picky Eater
____Colic	____Hives	____Diarrhea	____Celiac Disease
____Constipation	____Skin Rashes	____Vomiting	____Leg Aches
____Gas	____Fussiness	____Food Allergies	_____Other_____
____Other_____		____Other_____	

Do you have a history of allergies or food intolerance?_____Yes_____No

Most meals eaten?_____at home_____at restaurants Do you feel better if you skip a meal?_____Yes_____No

Are there foods that make symptoms worse?_____Yes_____No List:_____

Are there foods that make symptoms better?_____Yes_____No List:_____

Do you often wake up at night? If Yes, do you eat or drink? What? _____

Have you ever fasted? If Yes, did you feel_____Better_____Worse_____Same

Are there foods you crave? If yes, list_____

Are there any foods you binge on? If Yes, list_____

Do you have hypoglycemia?_____Yes_____No When you go on vacation do you feel_____Better_____Worse

Do family members have allergies or food intolerances?_____Yes_____No

Which foods would you miss most if you could not eat them for several days?_____

Surgical History:

In the last two years have you had any of the following?

____Sinus X-rays ____Chest X-rays ____Teeth X-rays ____Abdominal X-rays

____Brain Scan ____Bone Scan ____Body Scan ____Hearing Tests

____EKG ____Blood Tests ____Urine Tests ____TB Test

____Mammogram, If Yes, was it normal?_____Yes_____No Pap Smear, If Yes, was it normal?_____Yes_____No

What kind of doctors or specialists have you seen for your problems?

____Osteopath ____MD ____Psychologist ____Chiropractor

____Biofeedback ____Hypnosis ____Nutritionist ____Acupuncturist

Living Situation

Are you under stress?_____Yes_____No

Are you 15 pounds or more overweight?_____Yes_____No

Are you usually happy?_____Yes_____No

Do you like your job?_____Yes_____No

Are you usually satisfied with medical advice?_____Yes_____No

Do you exercise regularly?_____Yes_____No, If Yes, how often? _____

Do you use strong smelling cleaning chemicals?_____Yes_____No

Do you use pesticides in your home?_____Yes_____No

Do you use a lawn chemical company?_____Yes_____No

Is your hostility easily aroused?_____Yes_____No

Do you have crying spells?_____Yes_____No

Is anyone at home sick?_____Yes_____No

Do you have nightmares?_____Yes_____No

Are you sad?_____Yes_____No

Is your home treated regularly_____Yes_____No

Do you have pets/animals?_____Yes_____No, If Yes,_____Dog_____Cat_____Bird_____Hamster_____Rat

____Horse_____Rabbit_____Guinea Pig_____Other _____

Animals in the house?_____Yes_____No

Animals in the bedroom?_____Yes_____No

Is your pillow?_____Feather_____Down_____Foam_____Other_____

Is your mattress?_____Foam_____Box Spring_____Futon_____Waterbed_____Plastic Covered_____Other

Are your sheets and blankets?_____100% Cotton_____Wool_____Synthetic_____Other

Have you had any allergy testing?_____Yes_____No, If Yes, what type?_____Skin_____Blood

Are you taking any type of allergy treatment currently?_____Yes_____No, If yes, what?_____Prescription

____Over-the-counter ____Allergy Injections_____Avoidance

Have you been to emergency room for allergies or asthma?_____Yes_____No How often?_____

Do symptoms flare when starting heating in the winter?_____Yes_____No Worse ?_____Indoors_____Outdoors

Symptoms flare when going to bed?_____Yes_____No

Do you have nasal symptoms?_____Yes_____No

Environment

Do you live in____House____Apartment____Other How long in this residence?_____

Is garage attached____Yes ____No Is there much vegetation(trees, weeds, etc.)? ____Yes ____No

Is there a lot of dust in the home?____Yes ____No Does home have basement? ____Yes ____No

Is there mold/mildew in home?_Yes_No Is HVAC System?_Gas_Electric

Are your symptoms worse:

____Outdoors ____Indoors ____Rainy Days ____Windy Days

____Fall ____Summer ____Spring ____Winter

____At Night ____Weather Changes

Do you live near a power generating station/high voltage tower/transmitter?____Yes____No

Do you use electric blankets?____Yes____No Do you have indoor plants?____Yes____No

What kind of water do you drink?____Tap____Filtered____Plastic Bottled____Glass Bottled

Your Flooring Is: (Check all that apply)____Carpet/rugs____Wood____Tile____Vinyl____Cork

Review of Symptoms: Check those that apply:

Skin:

____Eczema ____Dry Skin ____Oily Skin ____Acne ____Hives

____Boils ____Herpes ____Split Nails ____Easy Bruising ____Face Swelling

Ear/Eyes/Nose/Throat:

____Ears Ring ____Dizziness ____Hay Fever ____Nasal Polyps ____Ear Infections

____Tubes in Ears ____Mouth Sores ____Sinus Infections____Post Nasal Drip____Hoarseness

____Gums Bleed ____Decayed Teeth____Glasses ____Contacts ____Cataracts

____Glaucoma ____Floaters ____Night Blindness____Light Sensitive ____Headaches

Headache Types:____ Migraine ____Sinus ____Tension

Headache Symptoms:____Flushing ____Nausea ____Loss of Sight ____Dazzling Lights

____Neck Pain ____Abdominal Pain____Vomiting ____Visual Disturbance

Endocrine:

____Fatigue ____Hypothyroid ____Hyperthyroid ____Diabetes:____Type II____Type I

____Hypoglycemia ____Adrenal Fatigue

Heart/Lungs:

____Asthma ____Emphysema ____Bronchitis ____Cough ____Short of Breath

____Chest Pain ____Heart Attack ____Heart Murmur ____Abnormal EKG ____Heart Races

____Heart Skips ____Ankles Swell

Gastrointestinal:

____Abdominal Pain ____Nausea ____Vomiting ____Gall Stones ____Vomited Blood

____Ulcer ____Heartburn ____Bloating ____Cramps ____Laxative Use

____Diarrhea ____Constipation ____Anal Itching ____Hepatitis ____Blood in Stool

____Belching ____Gas ____Regular Antacid Use ____Black Bowel Movements

Urinary Tract:

____Burning ____Urgency ____Blood in Urine ____Kidney Stones ____Kidney Disease

____Lose Urine When Coughs/Sneezes ____Bladder/Kidney Infections ____Hard to Start Urine

____Kidney Disease_____Void Small Amounts Urine Each Time You Go

Gynecology: (Females Only) At the time of your period, check all that apply:

____Fluid Retention_____Cramps ____PMS ____Depressed ____Irritable

____Heavy Bleeding_____Appetite Change____Irregular Flow ____Irregular Period_____Vaginal itching

____Yeast Infection ____Vaginal Itching ____Vaginal Discharge ____Bleeding Between Periods

____Menopause, If yes, What Age?_____ ____Vaginal Bleeding Since Menopause_____Pregnant

____Birth Control, If Yes, What Kind? _____

Date of last PAP Smear_____ ____Cervical Cancer Vaccine

Date of last period _____

____Breast Implants_____Any Miscarriages ____Lumps in Breasts ____Breast Pain

____Breast Discharge How many pregnancies?_____ ____Pregnancy Complications

Men Only: Check all that apply:

____Lump in Testicle ____Discharge from Penis ____Sores on Penis/Scrotum

____Painful Erection ____Inability to Sustain Erection ____You do not examine testicles monthly

Blood:

____Low White Count ____Anemia (Low Red Blood Count)____Easy Bruising ____Takes Iron

____Easy Bleeding ____Lymph Gland Swelling

Musculo-skeletal:

____Rheumatoid Arthritis	____Osteoarthritis	____Gout	____Muscle Spasms
____Joint Swelling	____Muscle Fatigue	____Restless Legs	____Painful Joints
____Swollen Joints	____Red Joints	____Neck Pain	____Other Pain

Neurology:

____Head Injury	____Blackout Spells	____Headaches	____Seizures
____Numbness	____Tingling	____Lost Ability to Speak	____Lost Ability to Move
____Dyslexia	____Trouble Thinking	____Learning Disabilities	____Trouble in School
____Memory Loss	____Trouble Explaining What You Mean		

IMMEDIATE FAMILY

Instructions: Please include all information you know related to the following areas.
y ou may need to ask your parents for a complete historv.

					Maternal		Paternal	
	Father	Mother	Brother	Sister	Grandmother	Grandfather	Grandmother	Grandfather
Age if living								
Age at death								
Cause of death								
Type of work								

Mar\. an "X" for any pos1t1ve answer

Asthma								
Allergy Hives								
Eczema								
Hayfever								
Weight Problem								
Smokers								
Alcohol Abuse								
Mental illness								
Cancer								
Diabetes								
Hypertension								
Heart problem								
HiQh cholesterol								
Thyroid disease								
Blood disease								
Bowel problem								
Ulcers								
Arthritis								
MiQraines								
Other								

Diet Diary: List all food and drinks typically eaten in a normal week. Include all snacks, fast food and drinks.

Sunday:

Breakfast:

Morning Snack:

Lunch:

Afternoon Snack:

Dinner:

Evening Snack:

Monday:

Breakfast:

Morning Snack:

Lunch:

Afternoon Snack:

Dinner:

Evening Snack:

Diet Diary Continued: List all food and drinks typically eaten in a normal week. Include all snacks, fast food and drinks.

Tuesday:

Breakfast:

Morning Snack:

Lunch:

Afternoon Snack:

Dinner:

Evening Snack:

Wednesday:

Breakfast:

Morning Snack:

Lunch:

Afternoon Snack:

Dinner:

Evening Snack:

Diet Diary Continued: List all food and drinks typically eaten in a normal week. Include all snacks, fast food and drinks.

Thursday:

Breakfast:

Morning Snack:

Lunch:

Afternoon Snack:

Dinner:

Evening Snack:

Friday:

Breakfast:

Morning Snack:

Lunch:

Afternoon Snack:

Dinner:

Evening Snack:

Diet Diary Continued: List all food and drinks typically eaten in a normal week. Include all snacks, fast food and drinks.

Saturday:

Breakfast:

Morning Snack:

Lunch:

Afternoon Snack:

Dinner:

Evening Snack:

Favorite Foods:

Mark all items:	DAILy	3 X WEEK	1-2 X WEEK	SELD0M	NEVER	CR/LA/0V/VE/E	LIKE	NEuTRIL	MCAHKI·1 ES LLDL
milk									
cheese									
oranoe juice									
apple iuice									
orape juice									
com syrup									
com meal									
popcorn									
peanut butter'									
sov products									
cram.,									
onion									
ootatos									
tomatoes									
beef									
chicken									
em:1s									
fish									
bacon									
sausaoe									
hot dogs									
sandwich meat									
bread, rolls									

Mark all items:	DAILy	3 X WEEK	1-2 X WEEK	SELD0M	NEVER	CR/LA/0V/VE/E	LIKE	NEUTRIL	MCAHKI·IES LLS DL
cereal									
oatmeal									
rice									
rye									
wheat									
cake cookies									
crackers									
pizza									
pasta									
sugar									
chocolate·									
coffee									
coffee (decaf)									
tea									
tea (decaf)									
honev									
mushroom s									
diet soft drinks									
soft drinks									
other									