Health History Form

PLEASE READ THE FOLLOWING ITEMS BEFORE FILLING OUT YOUR APPLICATION TO ENSURE ACCURACY:

Please make sure that this Application is complete and accurate. The information you put in this form will be released to designated health care providers when requested in a medical situation. All information provided to CALLMD is PRIVATE and CONFIDENTIAL.

- ✓ Please print all your entries.
- ✓ Please do not leave any question blank – even if your answer is "No" or "I don't know".
- ✓ If you are not sure about an answer or do not have the medical information you need, please consult your physician.
- ✓ If you are including additional pages of information, such as Lab or EKG results, Discharge Summary or Living Will, and to make us sure that we received them, please indicate the number of pages:_____
- ✓ Please read carefully and sign the CALLMD AUTHORIZATION TO RELEASE PATIENT INFORMATION at the end of this document. A parent or guardian must sign if the applicant is under the age of 18.
- ✓ place the completed CALLMD Application and any additional pages of information into the envelope provided and mail to:

2745 N. Dalllas Pkwy, Suite 600, Plano, TX 75093

- ✓ If you are unsure about any of the questions OR need assistance in filling-out this form, please call CALLMD at ☎ **(866) 568-6720**, between 8:30a and 4:30p CST, Monday through Friday.
- ✓ For quicker service, you may fax your application to **(214) 619-4206**.
- ✓ Your application will be processed within 24 hours of receipt.

Name

☐ PRIMARY ☐ DEPENDENT

Date of Birth

FIRST NAME	MI	LAST NAME	MM	DD	YYYY

EMAIL ADDRESS	CONFIRM – EMAIL ADDRESS

Home Address

APT/SUITE NO & STREET NAME	CITY

STATE	ZIP CODE	TELEPHONE NO - MOBILE	TELEPHONE NO - LANDLINE

Office Address

APT/SUITE NO & STREET NAME	CITY

STATE	ZIP CODE	TELEPHONE NO	TELEPHONE NO

PRIMARY Employer / Benefits Provider / HMO

NAME OF EMPLOYER/BENEFITS PROVIDER / HMO	POLICY/GROUP NO	ID NO

ADDRESS	TELEPHONE NO

SECONDARY Employer / Benefits Provider / HMO

NAME OF EMPLOYER/BENEFITS PROVIDER / HMO	POLICY/GROUP NO	ID NO

ADDRESS	TELEPHONE NO

Emergency Contact - 1

NAME	RELATIONSHIP*

ADDRESS	TELEPHONE - HOME	TELEPHONE - OFFICE

Emergency Contact - 2

NAME	RELATIONSHIP*

ADDRESS	TELEPHONE - HOME	TELEPHONE - OFFICE

*Spouse / Adult Son or Daughter / Mother / Father / Adult Brother or Sister / Other: please specify _____

LANGUAGE(S) SPOKEN

ENGLISH (YES/NO)	SPANISH (YES/NO)	CHINESE (YES/NO)	FRENCH (YES/NO)	GERMAN (YES/NO)	PORTUGUESE (YES/NO)	RUSSIAN (YES/NO)	ITALIAN (YES/NO)	OTHER

PHYSICAL CHARACTERISTICS

GENDER (F/M)	HEIGHT (FT" IN')	WEIGHT (LBS)	EYES (COLOR*)	GLASSES OR CONTACTS (YES/NO)	HEARING AID (YES/NO)	DENTURES (YES/NO)	SMOKE CIGARETTES (YES/NO)	SMOKE CIGARS OR PIPES (YES/NO)

*BLUE / BROWN / GREEN / GRAY / HAZEL

IDENTIFYING INFORMATION

DISTINGUISHING MARKS, TATTOOS OR SCARS. DESCRIBE TYPE AND LOCATION	
MOTHER'S MAIDEN NAME	PLEASE PROVIDE 4-DIGIT* **PIN** (PERSONAL IDENTIFICATION NUMBER)

*NUMBERS AND/OR LETTERS (UPPER OR LOWER)

BLOOD TYPE

O+ (Y/N)	**O-** (Y/N)	**A+** (Y/N)	**A-** (Y/N)	**B+** (Y/N)	**B-** (Y/N)	**AB+** (Y/N)	**AB-** (Y/N)	**DON'T KNOW** (Y/N)

ALLERGIES

I HAVE ALLERGIES: (Y/N)		IF YOU HAVE ALLERGIES, PLEASE COMPLETE THE FOLLOWING:	
MEDICATION		REACTION	
MEDICATION		REACTION	
BEE STINGS (Y/N)		REACTION	
X-RAY DYE (Y/N)		REACTION	
OTHER		REACTION	
OTHER		REACTION	

PRIMARY PERSONAL PHYSICIAN

Name	Specialty

Telephone NO.	Address

*ALLERGIST / CARDIOLOGIST / DERMATOLOGIST / OB-GYN / OPHTHALMOLOGIST / ORTHOPEDIST / PODIATRIST / INTERNIST /

OTHER: PLEASE SPECIFY: _____

SECONDARY PERSONAL PHYSICIAN

Name	Specialty

Telephone NO.	Address

*ALLERGIST / CARDIOLOGIST / DERMATOLOGIST / OB-GYN / OPTHALMOLOGIST / ORTHOPEDIST / PODIATRIST / INTERNIST /

OTHER: PLEASE SPECIFY: _____

PHARMACIES

PRIMARY: Name	Telephone NO
SECONDARY: Name	Telephone NO

SURGERY /MEDICAL PROCEDURES – If you have had surgery or a medical procedure, please complete the following . . .

Surgery / Medical Procedure	**Total number of times & how often?**	**Details**

MEDICATIONS – If you are currently taking medications . . .

Medication	**Dosage (mg., mcg., drops, units, etc.)**	**How often?**

PLEASE FILL-UP THE YEAR YOU HAD THE FOLLOWING MEDICAL CONDITIONS:

KIDNEY/URINARY TRACT	*YEAR*
Hemodialysis	
Incontinence	
Kidney Stones	
Polycystic Kidney Disease	
Pyelonephritis	
Recurrent Urinary Track Infection	
Renal Failure	
REPRODUCTIVE SYSTEM	***YEAR***
Ectopic Pregnancy	
Enlarged Prostate (BPH)	
Epididymitis	
Prostitis	
Uterine Fibroids	
LUNGS	***YEAR***
Asthma	
Chronic Bronchitis	
Emphysema	
Pneumonia	
Tuberculosis	

ENT (EAR/NOSE/THROAT)	*YEAR*
Hearing Impairment/ Deafness	
Nasal Polyps	
Sinus Problems (Sinusitis)	
Seasonal Rhinitis/Allergies	
EYES	***YEAR***
Astigmatism	
Blindness	
Cataracts	
Glaucoma	
Macular Degeneration	
SKIN	***YEAR***
Basal Cell Carcinoma	
Chronic Skin Ulceration	
Dermatitis	
Edema/Swelling	
Eczema	
Malignant Melanoma	
Psoriasis	
Rosacea	
Vitiligo	

HEART	*YEAR*
Angina/Chest Pain	
Arrhythmia/Palpitations	
Atrial Fibrillations	
Coronary Artery Disease	
Congestive Heart Failure	
Cholesterol Abnormality	
Endocarditis	
Fainting (Syncope)	
High Blood Pressure (Hypertension)	
Mitral Valve Prolapse	
Pericarditis	
VASCULAR	***YEAR***
Abdominal Aortic Aneurysm	
Cerebral Aneurysm	
Peripheral Vascular Disease/ Claudication	
Varicose Veins	
GLANDS/ENDOCRINE SYSTEM	***YEAR***
Adrenal Insufficiency/ Addison's Disease	
Diabetes	
Thyroid Disease	

PLEASE FILL-UP THE YEAR YOU HAD THE FOLLOWING MEDICAL CONDITIONS:

BONES/JOINTS/MUSCLES (RHEUMATOLOGY)	YEAR
Arthritis	
Back/Spine Problems- location:	
Collagen Vascular Disease (e.g. Lupus, Scleroderma, etc)	
Fibromyalgia	
Muscular Dystrophy	
Myasthenia Gravis	
Sciatica	
Tendonitis/Bursitis	
GASTROINTESTINAL TRACT	**YEAR**
Cirrhosis	
Gall Bladder Disease	
Hiatal Hernia/Reflux	
Hepatitis	
Hernia	
Inflammatory Bowel Disease	
Irritable Bowel syndrome	
Pancreatitis	
Peptic Ulcer Disease	

BLOOD /CANCER	YEAR
Anemia	
Cancer - Specify type	
Hemophilia / other bleeding disorder	
Leukemia	
Lymphoma	
Multiple Myeloma	
Sickle Cell Disease	
Thalassemia	
MISCELLANEOUS	**YEAR**

NEUROLOGIC	YEAR
Alzheimer's Disease	
Carotid Artery Disease	
Cerebral Palsy	
Cluster Headaches	
Meniere's Disease	
Migraine Headaches	
Multiple Sclerosis	
Parkinson's Disease	
Seizures/Epilepsy	
Stroke	
Vertigo/Chronic Dizziness	

FAMILY HISTORY

1. For each of the conditions listed, place an "X" in the box for each family member with a history of that condition.
2. If there is no history of any of the conditions for a listed family member, place an "X" in the "No History" box for that relative.
3. If you don't know the medical history of a family member, place an "X" in the "History Unknown" box for that relative.

	FATHER	MOTHER	SIBLING	GRAND PARENT	OTHER BLOOD RELATIVE
No History					
History Unknown					
Anemia					
Congestive Heart Failure					
Coronary Artery Disease					
Angina					
High Blood Pressure					
Diabetes					
Asthma					
Epilepsy/Seizure					
Mental Illness					
Glaucoma					
Ulcer					
Cancer (specify)					
Cancer (specify)					
Other (specify)					
Other (specify)					

IMMUNIZATIONS – Put an "X" in the appropriate box . . .

IMMUNIZATION	*YEAR*	*DON'T KNOW*	IMMUNIZATION	*YEAR*	*DON'T KNOW*
DPT (Diphtheria, Pertussis, Tetanus)			Measles Booster		
MMR (measles, mumps, rubella)			Hepatitis B		
HIB (haemophilus B conjugate)			Pneumovax		
Polio			Flu		
Varicella			Typhoid		
Tetanus Booster			Cholera		
Yellow Fever			Hepatitis A		

ADVANCE DIRECTIVES – Put an "X" in the appropriate box . . .

	YES	*NO*		*YES*	*NO*
I have a Living Will			I am including a copy		
I have a Health Care Proxy or Power-of-Attorney for Health Care			I am including a copy		
I am an Organ Donor			I am including a copy		

TERMS OF MEMBERSHIP

This AGREEMENT, between CALLMD, (the **Company**), and the enrolled person (**Client**), with respect to **Client**'s enrollment in the **Company**'s electronic medical record storage and/or telephonic physician consultant services, as selected by **Client** (the **Program**), on the date agreed to by the parties. In consideration of these premises and the mutual promises and covenants hereinafter contained, **Company** and **Client**, each intending to be legally bound hereby, agree as follows:

Section 1. **Company**'s Obligations. **Company** shall provide the **Program** to **Client** so long as **Client** pays the fees agreed to in connection with the **Program**. **Client** shall enroll in the **Program** and register with **Company** in the manner prescribed by **Company**. **Client** shall continue to have access to the **Program** until **Client** terminates his or her membership in the **Program**, or **Company** or **Client** terminates such membership as permitted under this Agreement. The **Program** encompasses the services described by **Company** in its enrollment materials.

Section 2. **Client**s Obligations. **Client** shall pay **Company** the fees for the **Program** as set forth in the enrollment materials.

Section 3. Term. The initial term of this Agreement (Initial Term) shall end one (1) year from the effective date of this Agreement. Upon expiration of the Initial Term, this Agreement shall automatically renew for successive one (1) year terms (each a Renewal Term) unless written notice is given at least ninety (90) days prior to the effective date of any Renewal Term.

Section 4. Amendment. This Agreement shall automatically terminate upon the liquidation, dissolution, cessation of business or the filing of a bankruptcy petition by or against either party. Upon termination of this Agreement for any reason, **Client** shall pay **Company** for all services rendered through the effective date of termination. This Agreement may only be amended from time to time by a writing signed by both parties. No waiver by **Client** or **Company** of any provision herein, shall operate as a waiver of any other provision or the same provision on a future occasion.

Section 5. Limitation of Liability. **Company** shall have no liability whatsoever for any indirect, consequential, exemplary, special, incidental or punitive damages. **Company**'s liability to **Client** for any reason and upon any cause of action, whether tort, contract, statute or any other legal theory whatsoever, shall be at all times and in the aggregate be limited to the lesser of (a) $1,000, or (b) the amount of compensation actually paid by **Client** to **Company** during the three (3) month period immediately preceding the month in which the event upon which the liability is predicated.

Section 6. Assignment. The rights and obligations of the assigning party under this Agreement shall not be assigned to any other individual, firm, corporation, association or other entity without the prior written approval of the non-assigning party, which approval shall not be unreasonably withheld, delayed or conditioned; provided that nothing contained in this Agreement shall prevent assignment or be deemed assignment of this Agreement in connection with the merger, sale of capital stock or sale of all or substantially all of the assets of **Company**.

Section 7. Disclaimer. **Company** does not make any express or implied representations or warranties, including but not limited to any warranty of merchantability or fitness for a particular purpose with respect to the **Program**.

Other Provisions. This document contains the entire Agreement of the parties. It supersedes any and all prior agreements, understandings or representations, whether oral or written. Neither party shall be responsible for delays in performance due to strikes, riots, acts of God, shortages of labor or materials, war, governmental laws, regulations, or restrictions, transportation conditions, product/service suppliers or any other causes whatsoever that are beyond the reasonable control of **Company**. This Agreement shall be interpreted exclusively according to the laws of the State of Texas without regard to its conflicts of laws principles. Any paragraph titles or captions contained in this Agreement are for convenience only and shall not be deemed part of the context of this Agreement. Except as set forth herein, the parties hereto do not intend to confer any rights or remedies upon any person other than the parties named below.

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I hereby authorize CALLMD and CALLMD Physicians Association and/or its member physicians to release and furnish on a confidential and strict need-to-know basis all medical and financial data related to my care that may be necessary now or in the future to facilitate payment by third parties for services rendered by Physician, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes, evaluation purposes. Such information may be released to insurance companies, HMOs and PPOs managed care organization, Medicare/Medicaid or other governmental or third party payors, or any organization contracting with any of the above entities to perform such functions. I also give authorization to have a copy of my medical records delivered to a primary care physician or any other physician that is directly or indirectly responsible for my medical care or the payment thereof.

_____ Date: _____/_____/_____

PLEASE PRINT NAME AND SIGN. Parent or guardian must sign for a member under 18 years of age.

- Please do not write below this line -

DFB TPA Services LLC

CUSTOMER NUMBER

	YES	NO
Start-up Kit		

	YES	NO
Membership Card		