DPC IN TEXAS
Office address: 7311 S Hulen st
Fort Worth Tx 76311

DIRECT PRIMAERY CARE IN TEXAS
EVELY E, OSUNDE APRN, FNP-C

Patient Information Form

Name : ____

Address: ____

Town: ___________________ State: __________ Zip Code: ___________

Phone # : home #_____________________ cell# __________________

Date of birth: _______________ SS #: ____________________

Medical Issues: Please circle all that apply

Hypertension Diabetes Thyroid Disease Cancer Heart Attack Stroke
other:

Past Surgeries: type and date

Please list all medications (prescription and over the counter)
Name Strength Dosage

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Name ________________________________

Allergies:

Are you allergic to Latex? Y N
Do you have medicine allergies? Y N
Another other allergies? Y N
If yes, please explain:

Family History:
Are you parents alive?

Mother Y N if no: age of death cause of death

Father Y N if no: age of death cause of death

Family Medical Issues:

High Blood Pressure	Father	Mother	Grandfather	Grandmother
Diabetes	Father	Mother	Grandfather	Grandmother
Hyperthyroidism	Father	Mother	Grandfather	Grandmother
Hypothyroidism	Father	Mother	Grandfather	Grandmother
Heart Attack	Father	Mother	Grandfather	Grandmother
Stroke	Father	Mother	Grandfather	Grandmother
Colon Cancer	Father	Mother	Grandfather	Grandmother
Breast Cancer	Father	Mother	Grandfather	Grandmother

Other family history:

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Consent for Medical Treatment Form

I, the undersigned (patient or the patient's duly authorized representative) do hereby voluntarily consent to and authorize medical care encompassing all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the Provider or his designees.

I am fully aware that the practice of medicine and surgery is not an exact science and acknowledge that no guarantee has been made to me as to the result of treatment or examination performed.

This form has been fully explained and discussed with me prior to any proposed testing or any type of surgical procedures scheduled.

I certify that I understand and accept the contents of this form.

Name of Patient ______________________________________

Name of Representative(if applicable): ____________________________

Signature of Patient : ____________________________________

Signature of Representative: _______________________________

Date: _________________

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HIPPA FORM

I, __________________________ give DPC and his staff my permission to discuss my medical conditions, including but not limited to medications, prognosis and financial information, with the following:

Name phone # relationship

____

Signature /date

COSMETIC SURGERY INFROMATION

Date of surgery: ____________________

Type of Surgery ______________________________

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