



# AYMAN CARE

## Primary Care

8208 Bedford Euless Road  
North Richland Hills, TX 76180

PH: (817) 581-5959 Fax: (682)334-0462

Email: [aymancare2019@gmail.com](mailto:aymancare2019@gmail.com)

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Height: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_

Best phone number to contact you: \_\_\_\_\_ Email Address: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

### HIPPA PRIVACY, FINANCIAL RESPONSIBILITY POLICY AND AUTHORIZATION TO TREAT

Our Practice Privacy (notice) provides information about how we may use and or disclose protected health information about you. You have the right to review our notice before signing this consent. As outlined in our notice if it is changed or modified, you may obtain a revised copy upon request. You have the right to request that we restrict operations. We are not required to agree to this restriction but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment payment, and healthcare operations. This consent is given freely with the understanding that

1. Any and all records whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original.
3. I may revoke this consent at any time except where information has already been released. This consent is valid until revoked by me in writing.

Do you give Ayman Care Primary Care permission to speak to your emergency contact regarding your treatment and care? Circle One: Yes or No Social Security # \_\_\_\_\_ (optional)

**ETHNICITY:** Please circle the ethnicity you most identify with. SS # \_\_\_\_\_ (optional)  
Caucasian Asian Black/African American Hispanic/Latino Descent Other Race \_\_\_\_\_

**GENDER:** Please Circle: Male Female

Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



**MEDICATIONS:** Are you currently taking any medication?  Yes or  No  
 If yes, please list the name, strength, and dosage below.

Medication Name	Strength	Dosage

**PAST MEDICAL AND PHYSICAL HISTORY:**

Please circle any that applies

- |                         |                         |                     |
|-------------------------|-------------------------|---------------------|
| Anxiety                 | Depression              | Hyperthyroidism     |
| Arthritis               | Diabetes                | Hypothyroidism      |
| Asthma                  | End Stage Renal Failure | Leukemia            |
| Atrial Fibrillation     | Gerd (heartburn)        | Lung Cancer         |
| BPH (prostate enlarged) | Hearing Loss            | Lymphoma            |
| Transplant              | Hepatitis               | Pacemaker           |
| Breast Cancer           | High Blood Pressure     | Prostate Cancer     |
| Colon Cancer            | HIV/AIDS                | Radiation Treatment |
| Heart Disease           | High Cholesterol        | Seizures            |
| Stroke                  | Skin Irritation         | Seasonal Allergies  |

Other \_\_\_\_\_

**ALLERGIES:**

Are you allergic to any medication or medical products?  Yes or  No/Unknown  
 If yes, list the medication/product and type of reaction (rash, shortness of breath, etc.)

**OB/GYN HISTORY:**  N/A

No. of pregnancies: \_\_\_\_\_ No. of deliveries: \_\_\_\_\_ Last menstrual cycle: \_\_\_\_\_



**PAST SURGICAL HISTORY:** Have you ever had any surgeries or c-sections in the past?

Yes or  No

If yes, please specify procedure(s) and approximate month and year

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**HOSPITALIZATION:**

Have you recently been admitted to a hospital overnight or > 12 hours?  Yes or  No

If yes, please specify the reason and the approximate month and year

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**FAMILY HISTORY:**

Are your biological parents still alive?  Yes  No  Unkown

Please check below for any that applies to your family history. This can be anyone from your immediate family to uncles, aunts, and grandparents.

Please specify which side of the family (mother or father) by using **M** or **F**.

Medical History	Yes	No	Affected relative(s)
Diabetes			
Heart Attack/Hypertension			
Heart Disease			
Mental Illness			
Cancer*			
Other Significant Diseases**			

\*If you have a history of cancer, please specify which type here. \_\_\_\_\_

\*\*Please specify disease here. \_\_\_\_\_



**ALCOHOL HISTORY:**

Did you have a drink containing alcohol in the past year?  Yes or  No

If yes, how often did you have a drink containing alcohol in the past year?

Monthly or less  2 to 4 times/month  2 to 3 times/week  4+/week

**TOBACCO/DRUG HISTORY:**

Please check next to the term that matches your smoking history:

Current smoker  Former smoker  Nonsmoker  Current everyday smoker   
Current some day smoker  Light tobacco smoker  Heavy tobacco smoker

If you are a smoker, how many packs do you smoke in a day or week? Please specify.

\_\_\_\_\_

Do you use other tobacco products?  Yes or  No

Have you ever used illegal substances or intravenous drug use?  Yes  No,

If yes, please specify \_\_\_\_\_

**PHARMACY:**

In the event your provider prescribes medication, please list a pharmacy most frequently used for prescriptions.

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

**AYMAN CARE REFILL POLICY**

When requesting refills on medications, you must call your pharmacy 3-4 days prior to running out of medication and ask to fax a refill request to our office. Allow at least 2-4 business days for refills to be processed. Prescriptions are sent electronically to pharmacies and we do not do it over the phone. Additionally, Ayman Care is not a pain management clinic nor a psychiatrist office. If you are currently on pain medication, antidepressants, sleep medication, or tranquilizers, Ayman Care providers may fill your prescription for 30 days at their discretion. You may be referred to pain management or psychiatrist/therapist by our office or if you would like to choose, you can contact MHMR for mental health treatment. Ayman Care holds the right to amend this document at any time.

Signature of Patient/Guardian: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_



## **GENERAL CONSENT**

**Consent for Treatment:** By signing, I consent to any and all health care treatment and diagnostic procedures provided by Ayman Care and its associated physicians, clinicians and other personnel. I understand that no guarantee has been or can be made as to the result of the treatments or examinations at Ayman Care.

**Assignment of Benefits:** By signing, I authorize Ayman Care to submit claims on my behalf directly to Medicare/medicaid/my private health insurance carrier. I understand that I am financially responsible to the provider(s) for the charges not paid or payable by my insurance.

## **AYMAN CARE REFILL POLICY**

When requesting refills on medications, you must call your pharmacy 3-4 days prior to running out of medication and ask to fax a refill request to our office. Allow at least 2-4 business days for refills to be processed. Prescriptions are sent electronically to pharmacies and we do not do it over the phone. Additionally, Ayman Care is not a pain management clinic nor a psychiatrist office. If you are currently on pain medication, antidepressants, sleep medication, or tranquilizers, Ayman Care providers may fill your prescription for 30 days at their discretion. You may be referred to pain management or psychiatrist/therapist by our office or if you would like to choose, you can contact MHMR for mental health treatment. Ayman Care holds the right to amend this document at any time.

**Signature of Patient/Guardian:** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_



## Patient Health Questionnaire (PHQ-9)

Name: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

	Not at all 0	Several Days 1	More than half the days 2	Nearly every day 3
1) Little interest or pleasure in doing things				
2) Feeling down, depressed, or hopeless				
3) Trouble falling or staying asleep, or sleeping too much				
4) Feeling tired or having no energy				
5) Poor appetite or overeating				
6) Feeling bad about yourself or that you are a failure, or have let yourself or your family down				
7) Trouble concentrating on things, such as reading the newspaper or watching television				
8) Moving or speaking so slowly that other people could have noticed, or the opposite, being so fidgety or restless that you have been moving around a lot more than usual				
9) Thoughts that you would be better off dead or of hurting yourself or other(s) in some way				

**Total Score:** \_\_\_\_\_

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "X" to indicate your answer)

**Interpretation of Total Score for Depression Severity:**

- \_\_\_ (1-4) Minimal Depression
- \_\_\_ (5-9) Mild Depression
- \_\_\_ (10-14) Moderate Depression
- \_\_\_ (15-19) Moderately Severe Depression
- \_\_\_ (20-27) Severe Depression