

Dallas Medical & Mckinney Internal Medicine

Vijaya Mummadi, M.D., Rachel Jaison, F.N.P.

9900 N Central Expwy, Ste 225, Dallas, TX 75231

8820 Collin McKinney Pkwy, McKinney, TX 75070

P: 469-646-8880, F: 469-646-8884

P: 214-556-0847, F: 214-556-0850

PATIENT INFORMATION:

Please print clearly and fill out completely:

Primary Care Physician _____ Referred By _____

Name _____

First _____ Middle _____ Last _____

Address _____

Street _____ Apt _____ City _____ State _____ Zip _____

Home Phone () _____ Work Phone () _____ Mobile () _____ Beeper () _____

Date of Birth / / Age _____ Social Security# _____ Driver License _____ State _____

Name of Employer _____ Phone# () _____

Address _____ City _____ State _____

Marital Status _____ Spouse/Significant Other's Name _____ Date of Birth / / _____

Primary Insurance Information

Name of Insurance _____

Insurance Address for Claims _____ City _____ State _____ Zip _____

Name of Insured _____ Relationship to Patient _____

Insured's Information:

Date of Birth / / Insured's Social Security# _____ Member# _____ Group# _____

Insured's Employer _____ Phone# () _____

Insured's Employer Address _____ City _____ State _____ Zip _____

Secondary Insurance Information

Name of Insurance _____

Insurance Address for Claims _____ City _____ State _____ Zip _____

Name of Insured _____ Relationship to Patient _____

Insured's Information:

Date of Birth / / Insured's Social Security# _____ Member# _____ Group# _____

Insured's Employer _____ Phone# () _____

Insured's Employer Address _____ City _____ State _____ Zip _____

Nearest Friend or Relative Not Living with You (in case of emergency)

Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Home Phone () _____ Business Phone () _____ Mobile () _____ Beeper () _____

I hereby assign to Dallas Medical any money payable to me under hospitalization or other insurance coverage, and/or arrangements with their parties, for payment of such services. I authorize Dallas Medical to furnish my insurance company the medical information requested. I agree to be responsible for any testing or treatment that may not be considered by my insurance company, to be medically necessary. I also agree to pay Dallas Medical \$60.00 for no show appointments if not properly canceled within 24 hours prior to the scheduled appointment.

Signature _____ Date / / Account# _____

Dallas Medical & Mckinney Internal Medicine

Vijaya Mummadi, M.D., Rachel Jaison, F.N.P.

9900 N Central Expwy, Ste 225, Dallas, TX 75231 8820 Collin McKinney Pkwy, McKinney, TX 75070

P: 469-646-8880, F: 469-646-8884

P: 214-556-0847, F: 214-556-0850

NEW PATIENT HISTORY

Name: _____, Date of birth (DOB): _____

Local pharmacy name and crossroads: _____ Mail order pharmacy name: _____

Social History: Hours and type of exercise per week: _____

Smoking/Tobacco use: Yes/No, Number of packs per day: ____, [] Quit? When ____, Never Smoked: []

Alcohol use: Yes/No, Number of caffeinated drinks/day on average: ____, **Recreational drug use:** Yes/ No

Marital Status: [] Married, [] Single, [] Divorced, [] Widowed, [] Partnered

Occupation: _____ **Residence:** Home / Apartment / Assisted Living

Memory impairment: Yes/No,

Hearing impairment: Yes/No, **Hearing Aid:** Yes/No

Snoring: Yes/No, **Dry mouth when wakes up in the morning?** Yes/No, **Excessive Daytime sleepiness:** Y/N

Falls: Yes/No, **Number of falls in last 1 year:** _____

Do You Drive: Yes/No,

Corrected Vision when driving? (glasses, contacts, etc): Yes/No

Medical Living will/Advance directives: Yes/No

Medical Power of Attorney: Yes/No, **If yes:** Name and contact information: _____

DNR (Do not resuscitate): Yes/No

Sexual Health History: Sexual partners: Male []/ Female [], Any STIs: _____

Preventive Health History- last screening dates:

Bone density scan (DEXA): _____ **Skin exam:** _____

cardiac stress test: _____, **Diabetic foot exam (if diabetic):** _____

Colonoscopy: _____, **Dental exam:** _____

Last Immunizations (vaccine) dates: please mark N/A if you have not done the vaccines

Flu: _____ Pneumonia(Prevnar 20 or Pneumovax 23): _____

Tetanus (TDaP): _____ Shingles: _____ Gardasil (HPV vaccine) _____

Hepatitis B: _____, RSV: _____, COVID 19: _____

Women's health & last screening dates: PAP smear: _____, Mammogram: _____

Do you perform monthly self-breast exams? **Yes/No**, Have you had an abnormal PAP smear? **Yes/No**

Have you had an abnormal mammogram? **Yes/No**

Men's health & last screening dates: PSA level: _____, Any abnormal PSA level: **Yes/No**

Do you perform monthly self testicular exams (ages 18 – 39 only): **Yes/No**

Are you referred by: [] Google, [] ZocDoc, [] Friend: _____, [] Doctor: _____

Patient signature: _____, **Today's date:** _____

Dallas Medical & Mckinney Internal Medicine

Vijaya Mummadi, M.D., Rachel Jaison, F.N.P.

9900 N Central Expwy, Ste 225, Dallas, TX 75231 8820 Collin McKinney Pkwy, McKinney, TX 75070

P: 469-646-8880, F: 469-646-8884

P: 214-556-0847, F: 214-556-0850

Medications list: (please include – name, dose and frequency and if as needed), [] separate list attached

Drug allergies: Yes/No, If yes (name of the drug and the reaction): [] separate list attached

List of all Medical conditions: [] separate list attached

List of all prior surgeries (please add year if you remember): [] separate list attached

List reasons for all prior hospitalizations (please add year if you remember): [] separate list attached

Family medical history (in blood relatives only), please provide the correct relationship and age when they got diagnosed:

Breast cancer: _____

Ovarian cancer: _____

Colon cancer: _____

Prostate cancer: _____

Diabetes: _____

Hypertension: _____

High cholesterol: _____

Stroke: _____

Heart disease: _____

Others: _____

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date _____ Patient Name: _____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Please circle your answers.

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
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.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all

Somewhat difficult

Very Difficult

Extremely Difficult

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Please circle your answers.

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all

Somewhat difficult

Very Difficult

Extremely Difficult

UHS Rev 4/2020

Epworth Sleepiness Scale

Name: _____ Today's date: _____

Your age (Yrs): _____ Your sex (Male = M, Female = F): _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

- 0 = would **never** doze
- 1 = **slight chance** of dozing
- 2 = **moderate chance** of dozing
- 3 = **high chance** of dozing

It is important that you answer each question as best you can.

Situation	Chance of Dozing (0-3)
Sitting and reading _____	_____
Watching TV _____	_____
Sitting, inactive in a public place (e.g. a theatre or a meeting) _____	_____
As a passenger in a car for an hour without a break _____	_____
Lying down to rest in the afternoon when circumstances permit _____	_____
Sitting and talking to someone _____	_____
Sitting quietly after a lunch without alcohol _____	_____
In a car, while stopped for a few minutes in the traffic _____	_____

THANK YOU FOR YOUR COOPERATION

Patient name: _____

Date of birth: _____

Alcohol screening questionnaire (AUDIT)

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:



12 oz.
beer



5 oz.
wine



1.5 oz.
liquor
(one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year

Have you ever been in treatment for an alcohol problem? Never Currently In the past

I II III IV
0-3 4-9 10-13 14+

Dallas Medical & McKinney Internal Medicine

Vijaya Mummadi, M.D., Rachel Jaison, F.N.P.

9900 N Central Expwy, Ste 225, Dallas, TX 75231 8820 Collin McKinney Pkwy, McKinney, TX 75070

P: 469-646-8880, F: 469-646-8884

P: 214-556-0847, F: 214-556-0850

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and coworkers.

Please circle your response to the following:

May we leave messages concerning your appointments with a coworker, receptionist, or secretary that regularly answers your calls? YES NO N/A

May we leave detailed messages on your voicemail at work? YES NO N/A

May we leave detailed messages on your voicemail at home? YES NO N/A

May we leave detailed messages on your cell phone? YES NO N/A

(Please remember that your cell phone is not a secure line)

Please list names of persons with whom we have permission to discuss your appointments, treatments or financial issues:

Name:

Relationship:

May we correspond with you via email? YES NO N/A

Your email: _____@_____

You must inform us in writing of any changes in your directives. This consent takes effect on the date indicated below and will be kept in your file along with your acknowledgement of receipt of your Notice of Privacy Practices.

Signature: _____ Date: _____

Print Name: _____ Date of birth: _____

Dallas Medical & Mckinney Internal Medicine

Vijaya Mummadi, M.D., Rachel Jaison, F.N.P.

9900 N Central Expwy, Ste 225, Dallas, TX 75231 8820 Collin McKinney Pkwy, McKinney, TX 75070
P: 469-646-8880, F: 469-646-8884 P: 214-556-0847, F: 214-556-0850

CONSENT FOR TREATMENT

I voluntarily consent to such medical or surgical procedures, care, or treatments by my physician as are deemed necessary for me in her professional judgment. I also consent to the same with regard to her assistants' or designees' services rendered under her general or specific instructions.

I also acknowledge that the practice of medicine is an inexact science and that no guarantees can be made to me with regard to results of diagnostic or therapeutic examinations, evaluations, procedures, or treatments.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical insurance benefits to Dallas Medical for services rendered by the physician in person or by her assistants under her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

I also understand that all laboratory tests, radiology and diagnostic procedures, or other pathology exams ordered by my physician will be sent to outside facilities and could be billed separately by these facilities. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Dallas Medical to release any medical or incidental information that may be necessary for my medical care or for processing applications for insurance benefits.

MEDICARE/MEDICAID

I certify that the information given by me in applying for payment is current. I authorize release of all records on request of the authorized relevant government agency. I request that direct payment of authorized benefits be made to Dallas Medical on my behalf.

A photocopy of these assignments shall be as valid as the original.

PATIENT'S PRINTED NAME: _____ DATE: _____

PATIENT'S SIGNATURE: _____ DOB: _____

PARENT/GUARDIAN NAME: (if required) _____

PARENT/GUARDIAN SIGNATURE: (if required) _____

Dallas Medical & McKinney Internal Medicine

Vijaya Mummadi, M.D., Rachel Jaison, F.N.P.

9900 N Central Expwy, Ste 225, Dallas, TX 75231 8820 Collin McKinney Pkwy, McKinney, TX 75070

P: 469-646-8880, F: 469-646-8884

P: 214-556-0847, F: 214-556-0850

Medical Release of Information Form

Patient's name: _____ Date of Birth: _____

Previous Name (if applicable): _____

I request and authorize release of, or request access, to information specified below FROM:

Doctor's Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Please release the medical record of the above named patient to:

DALLAS MEDICAL, PLLC

or

McKinney Internal Medicine

9900 North Central Expwy., Ste 225

8820 Collin McKinney Pkwy.

Dallas, Tx 75231

McKinney, Tx 75070

F: 469-646-8884

F: 214-556-0850

PLEASE MAIL RECORDS

DO NOT FAX RECORDS IF OVER 20 PAGES

This request and authorization applies to: (initial appropriate line)

____ Health Care information relating to the following treatment condition or dates of treatment:

____ All Health Care information including information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders/mental health or drug and /or alcohol use.

____ All Health Care information excluding information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders/ mental health or drug and /or alcohol use.

Signature of patient or authorized representative

Date

Relationship if signed by anyone other than the patient (parent, legal guardian, personal representative etc.)

This release expires 90 days after the date it is signed.

Dallas Medical & Mckinney Internal Medicine

Vijaya Mummadi, M.D., Rachel Jaison, F.N.P.

9900 N Central Expwy, Ste 225, Dallas, TX 75231 8820 Collin McKinney Pkwy, McKinney, TX 75070

P: 469-646-8880, F: 469-646-8884

P: 214-556-0847, F: 214-556-0850

Patient Information - Office Policies and Procedures Revised 04/15/2025

New Patients Appointments for new patients include a comprehensive history and physical examination, The overall visit takes about one hour. New patients will be asked to arrive 15 minutes before their appointment to fill out paperwork.

Your appointment: Your Appointments are scheduled during regular office hours, Monday through Friday, between 8:30AM to 3:45 PM. Be sure to Check-in at the front desk upon arrival at the office. While I strive to be on time, emergencies do occur. So, please be patient with us. If you are running late, I will do my best to accommodate you the same day, but on-time patients will be given first priority. **If you are more than 10 minutes late, you may be rescheduled if we cannot accommodate you into an open appointment time.** As a courtesy, you will receive a reminder call 1 day before your appointment and you will receive text and email notifications if you have provided that information when you booked your appointment (for new patients). If you need to cancel your appointment, you must give us a 24 hour notification. Any patient who does not cancel less than 24 hours or "no-shows" for an appointment may be charged a \$60 fee that must be paid before another appointment is made.

Payment for Medical Care: Payment is to be made at the time when medical care is rendered, which is at the time of appointment. The responsibility for the payment of these fees is the direct obligation of the patient. We accept various payment forms like checks and various credit cards. We try to avoid taking payments as cash. Many medical services are covered by health insurance and our office will file your insurance claim for you. However, you are responsible for payment of your medical bills if insurance does not pay us as part of deductible or your co-pay. If you are a cash pay patient, most of the visit payments will be due at the time of the visit. However, depending on all the services rendered, there may be an additional balance to be paid later. Any financial benefits you receive from insurance companies or government agencies are a matter of settlement solely between you and the agency involved. Any bills you receive from lab or imaging companies are between you and them. I do not have any role in it. However, if you provide us with the invoice you received from these companies, we can check with their representatives to see if there is any additional coding help we can do to improve the payment for you. **As every insurance is different and each insurance has its own subplan categories, we will not know every detail of their payments unfortunately including the part of us being in Network or not. It is your responsibility to make sure that we are in network with your insurance and also to know what services your insurance plan would pay and would not pay and guide us.** We do not keep any credit card on file and hence it is your responsibility to contact us and make a payment when you receive your statement. After 3 statements if there is still no payment made by you, there is a chance the balance will be sent to collections.

Routine Follow-up Appointments: Many chronic medical conditions such as high blood pressure, diabetes, thyroid disease, etc. require frequent monitoring by your doctor. You will be asked to schedule appointments in order to be examined, check blood-work, and adjust medications. Refills on most

chronic maintenance medications will be only given for 90 days if you are coming regularly for your visits. For your own safety, 1 year prescription refills will give only on specific medications and your provider will discuss that with you at your visit. You must bring a list of all your current medications including dosage to each visit.

Annual Physical Exams: All patients need to have annual exams in order to review screening and preventative health measures. At this appointment, immunizations, safety measures, new technologies, and treatments will be discussed. I strongly encourage you to make this appointment within the same calendar month each year. **Routine follow-up and acute problems will not be addressed at this visit.**

Problem or Acute Appointments: For acute problems or illnesses, appointments on the same or next day will be available. Please call as early in the day as possible to be worked on quickly. If you have a life threatening problem, please call 911 or proceed to the nearest emergency room. Antibiotics will not be called in without seeing you for an appointment as you need to be seen to determine an appropriate treatment plan.

Hospitalizations: I do not admit patients to the hospital, but I work closely with the in-hospital physician group at Texas Health Presbyterian Hospital, Dallas if you require hospitalization. If the hospital doctor contacts us for your records, we will provide them promptly. The in-house hospital group has coverage in the hospital 24/7, so any emergency situation can be taken care of promptly. I do have access to your hospital records on the hospital portal.

Recording: Both Audio and video recordings are prohibited in our office which may include but not limited to provider-patient conversation, office space recording, etc.

Questions: We highly encourage you to call during office hours. The medical assistants will help you out. Most calls are answered the same day. However, since a normal day is filled with appointments and emergencies, please be patient while we attempt to handle non-emergency issues as soon as possible.

Release of PHI (Protected Health information): Any information you provide us is Protected Health Information and in accordance with HIPAA compliance we do not release any of your health information without your signed consent form to any entity except for your own health insurance company and the subspecialists that you see regularly.

Change in address, phone number or insurance: It is your responsibility to update us when there is a change in these to be able to timely send the balance statements, send you appointment reminders as well as be able to submit claims for insurance for timely processing.

ID and Insurance card: Please always bring your ID card and insurance card with you for your appointments. We would need these to update your information regularly. You need to at least provide us with an electronic copy of these before we are able to see you especially if you are a new patient.

A Final Note: It is my goal to provide you with the best comprehensive adult care in a pleasant environment. I consider it an honor and privilege to have you in my practice. Please let me know if you have questions about any aspect of my practice, including comments about my staff or the general office atmosphere. Thank you for your trust

Patient name: _____, Patient signature: _____, Date: _____