VALLEY VIEW
FAMILY MEDICAL CLINIC

Krystal Bewley, FNP-C
Polly Klement, FNP-C
Jill Buck, FNP-C
Lindsay Kirkwood, FNP-C
Chance Dingler, MD

909 North Frontage Rd
Valley View, TX 76272
Phone: 940-726-5750 | Fax: 940-726-5721

Patient Name: _____ Date of Birth: _____

Mailing Address: _____

City and State: _____ Zip: _____

Primary Phone: _____ Alternate Phone: _____

Gender: _____ Age: ____ SSN: _____

Email Address: _____ (required for patient portal account)

Ethnicity/Race: _____ Preferred Language: _____

Previous Physician (including location): _____

Preferred Pharmacy (including location): _____

Employer: _____ Employer Phone: _____

Parent/Guardian: _____ Parent/Guardian Date of Birth: _____

Emergency Contact Name & Phone: _____

How did you hear about Valley View Family Medical Clinic?: _____

I hereby authorize the release of medical information necessary to process my insurance claim and assign the doctor all payments from Medicare and other insurance carriers for services rendered. I also understand that I am responsible for the balance of my account. I understand and agree to the above conditions.

Patient Signature: _____ Date: _____

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ACKNOWLEDGE OF REVIEW OF PRIVACY PRACTICES

I hereby certify that I have been given the opportunity to review Valley View Family Medical Clinic's NOTICE OF PRIVACY PRACTICES, which explains how my protected health information will be used and disclosed. I understand that I am entitled to a copy of this document if I chose to have one.

COMMUNICATION AUTHORIZATION
and RELEASE OF INFORMATION TO AUTHORIZED REPRESENTATIVES

I give Valley View Family Medical Clinic permission to:

Leave a message on your voicemail / home messaging system regarding appointments, lab results, imaging reports or other such diagnostic reports? ☐ YES ☐ NO

Contact me at work (in emergency circumstances only) with lab results, imaging reports, other diagnostic test results or urgent health issues? ☐ YES ☐ NO

Discuss your health care issues with any member of your family or other authorized persons that I chose and have listed below? ☐ YES ☐ NO

If yes, please list the person(s) that are authorized below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Patient or Representative: _____ Date: _____

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Valley View, TX 76272

HEALTH HISTORY FORM

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____ Preferred Pharmacy: _____

Occupation: _____ Employer: _____

1. PAST MEDICAL HISTORY

Please check any of the following conditions you have been diagnosed with:

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Stroke / TIA
- ☐ Diabetes (Type 1 / Type 2)
- ☐ Thyroid Disorder
- ☐ Asthma / COPD
- ☐ Sleep Apnea
- ☐ GERD / Acid Reflux
- ☐ IBS / Digestive Disorder
- ☐ Liver Disease
- ☐ Arthritis
- ☐ Chronic Pain
- ☐ Anxiety
- ☐ Depression
- ☐ ADHD
- ☐ Migraines / Headaches
- ☐ Seizure Disorder
- ☐ Cancer (Type: _____)
- ☐ Anemia
- ☐ Autoimmune Disorder
- ☐ Gout
- ☐ Allergies (Seasonal)
- ☐ Other: _____

Please list any other medical conditions not listed above:

_____

_____

Past Surgeries / Procedures (include date):

_____

_____

Hospitalizations (include date and reason):

2. FAMILY MEDICAL HISTORY

Please check any of the following that apply to your immediate family (parents, siblings, children):

CONDITION	MOTHER	FATHER	SIBLINGS	CHILDREN
High Blood Pressure	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Mental Health Disorder	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐

Additional family history information:

_____

_____

_____

CURRENT MEDICATIONS (Prescription, OTC, Vitamins, Supplements)

	MEDICATION NAME	DOSAGE (How much do you take)	FREQUENCY (How often)	QUANTITY (How much do you have)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Medication Allergies (please list medication and reaction): _____

Other Allergies (food, environmental, etc.): _____

Thank you for providing this information.
It helps us provide you with the best possible care.

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HEALTH HISTORY FORM

3. PREVENTATIVE SCREENINGS

SCREENING	DATE (MO/YR)	RESULTS	WHERE DONE
Pap Smear	_____	_____	_____
Mammogram	_____	_____	_____
Colonoscopy	_____	_____	_____
Bone Density (DEXA)	_____	_____	_____
Prostate Screening (PSA)	_____	_____	_____
Eye Exam	_____	_____	_____
Dental Exam	_____	_____	_____
Immunizations	_____	_____	_____

4. SOCIAL HISTORY

TOBACCO USE

- ☐ Never
- ☐ Former (Quit date: _____)
- ☐ Current
  - Type: _____
  - How much: _____

DRUG USE

- ☐ Never
- ☐ Former
- ☐ Current
  - Type(s): _____

ALCOHOL USE

- ☐ Never
- ☐ Occasional
- ☐ Moderate ( ) drinks per week
- ☐ Heavy ( ) drinks per week

CAFFEINE USE

- ☐ Never
- ☐ Occasional (1–2 servings per day)
- ☐ Moderate (3–4 servings per day)
- ☐ High (5+ servings per day)

Type: _____

DIET

- ☐ Poor
- ☐ Fair
- ☐ Good
- ☐ Excellent

EXERCISE

- ☐ None
- ☐ 1–2 times per week
- ☐ 3–4 times per week
- ☐ 5+ times per week

Type of exercise: _____

How often: _____

LIVING SITUATION

- ☐ Live alone
- ☐ Live with spouse/partner
- ☐ Live with family
- ☐ Other: _____

SAFETY

Do you feel safe at home?

☐ Yes ☐ No

Do you have any concerns about:

- ☐ Falls
- ☐ Depression / Stress
- ☐ Other: _____

MARITAL STATUS

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Other: _____

5. ADDITIONAL INFORMATION

Is there anything else about your health that you would like us to know?

_____

_____

_____

FOR OFFICE USE ONLY

Reviewed by: _____ Date: _____

Thank you for providing this information.
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2026 TELEMEDICINE INFORMED CONSENT

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology including service interruptions, interception, and technical difficulties.
   a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my healthcare provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my right at any time by contacting Valley View Family Medical Clinic at 940-726-5750.
5. I understand that the laws that protect privacy and the confidentiality of healthcare information apply to telemedicine.
6. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
   b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurance that apply to my telemedicine visit.
   c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.
8. I understand my consent includes authorization for my provider to take a photograph/video of my visit to save in my file.

Patient Printed Name

Patient/Parent/Guardian Signature

Patient Date of Birth

Witness Signature

Date

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand, and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).