



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. Dallas 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 / OPHTHALMOLOGIST / 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:

<i>KIDNEY/URINARY TRACT</i>	<i>YEAR</i>	<i>ENT (EAR/NOSE/THROAT)</i>	<i>YEAR</i>	<i>HEART</i>	<i>YEAR</i>
Hemodialysis		Hearing Impairment/ Deafness		Angina/Chest Pain	
Incontinence		Nasal Polyps		Arrhythmia/Palpitations	
Kidney Stones		Sinus Problems (Sinusitis)		Atrial Fibrillations	
Polycystic Kidney Disease		Seasonal Rhinitis/Allergies		Coronary Artery Disease	
Pyelonephritis				Congestive Heart Failure	
Recurrent Urinary Tract Infection		<i>EYES</i>	<i>YEAR</i>	Cholesterol Abnormality	
Renal Failure		Astigmatism		Endocarditis	
		Blindness		Fainting (Syncope)	
<i>REPRODUCTIVE SYSTEM</i>	<i>YEAR</i>	Cataracts		High Blood Pressure (Hypertension)	
Ectopic Pregnancy		Glaucoma		Mitral Valve Prolapse	
Enlarged Prostate (BPH)		Macular Degeneration		Pericarditis	
Epididymitis					
Prostitis					
Uterine Fibroids		<i>SKIN</i>	<i>YEAR</i>		
		Basal Cell Carcinoma		<i>VASCULAR</i>	<i>YEAR</i>
<i>LUNGS</i>	<i>YEAR</i>	Chronic Skin Ulceration		Abdominal Aortic Aneurysm	
Asthma		Dermatitis		Cerebral Aneurysm	
Chronic Bronchitis		Edema/Swelling		Peripheral Vascular Disease/ Claudication	
Emphysema		Eczema		Varicose Veins	
Pneumonia		Malignant Melanoma			
Tuberculosis		Psoriasis		<i>GLANDS/ENDOCRINE SYSTEM</i>	<i>YEAR</i>
		Rosacea		Adrenal Insufficiency/ Addison's Disease	
		Vitiligo		Diabetes	
				Thyroid Disease	



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

BONES/JOINTS/MUSCLES (RHEUMATOLOGY)	<i>YEAR</i>	BLOOD /CANCER	<i>YEAR</i>	NEUROLOGIC	<i>YEAR</i>
Arthritis		Anemia		Alzheimer's Disease	
Back/Spine Problems- location:		Cancer - Specify type		Carotid Artery Disease	
Collagen Vascular Disease (e.g. Lupus, Scleroderma, etc)				Cerebral Palsy	
Fibromyalgia				Hemophilia / other bleeding disorder	Cluster Headaches
Muscular Dystrophy		Leukemia		Meniere's Disease	
Myasthenia Gravis		Lymphoma		Migraine Headaches	
Sciatica		Multiple Myeloma		Multiple Sclerosis	
Tendonitis/Bursitis		Sickle Cell Disease		Parkinson's Disease	
		Thalassemia		Seizures/Epilepsy	
GASTROINTESTINAL TRACT	<i>YEAR</i>			Stroke	
Cirrhosis		MISCELLANEOUS	<i>YEAR</i>	Vertigo/Chronic Dizziness	
Gall Bladder Disease					
Hiatal Hernia/Reflux					
Hepatitis					
Hernia					
Inflammatory Bowel Disease					
Irritable Bowel syndrome					
Pancreatitis					
Peptic Ulcer Disease					



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. **Clients 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		