HEART OF TEXAS FAMILY MEDICINE

REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Driver's License no.:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

FINANCIAL RESPONSIBILITY

Person responsible for bill:	Birth date: / /	Address (if different):	Home & Cell phone no.: ( ) ( )
Is this person a patient here?	❑ Yes ❑ No		

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Please indicate primary insurance.	Group No.:	Policy no.:	Co-Payment: $

Subscriber's Name:	Subscriber's Address:	Subscriber Ph. #	Subscriber SS #:	Sub. BirthDate:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize HEART OF TEXAS FAMILY Medicine or insurance company to release any information required to process my claims.

Patient/Guardian signature	*Date*

HEART OF TEXAS FAMILY MEDICINE

Patient Name: _____ Date of Birth: _____

Reason for today's visit?_____

Are you pregnant? Yes or No How many weeks? _____

Which pharmacy do you use? _____

Are you allergic to any medications?_____

Are you currently taking any medications? Yes or No

(Please list below or on back:)

Date began med	Medication	Dosage	How Is Medication Taken?	Who Prescribes this medication for you?
05/2001	**(Example) Metformin**	**500 mg**	**1 tab. 2 x /day**	**Dr. Smith**

Concerning matters of my health, I give permission for *Heart of Texas Family Medicine* staff to speak with:

_____, _____, _____
name of person(s) phone number relationship to patient

_____, _____, _____
name of person(s) phone number relationship to patient

X_____, _____/_____/_____
Signature of Patient or Guardian Date

HEART OF TEXAS FAMILY MEDICINE

Patient Name: _____ Date of Birth: _____

Medical History (check all that apply)

- ☐ ADD/ADHD
- ☐ Alcoholism
- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Bone or Joint Injuries _____
- ☐ Cancer _____
- ☐ COPD _____
- ☐ Depression _____
- ☐ Diabetes Type 1 or Type 2
- ☐ Drug Dependency
- ☐ Eczema / Skin Problems
- ☐ Gastric Reflux
- ☐ Genetic Disease _____
- ☐ Heart Disease _____
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus / Autoimmune Disorder
- ☐ Mental Illness
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ TB
- ☐ Thyroid Disease _____

Family History Please indicate which family members (father, mother, brother, sister, grandparent) have had the following health issues. Check all that apply.

Health Condition	Family Member(s)
☐ Aneurysm	_____
☐ Arthritis	_____
☐ Asthma	_____
☐ Cancer	_____
☐ Depression	_____
☐ Diabetes	_____
☐ Genetic Disease	_____
☐ Heart Disease	_____
☐ High Blood Pressure	_____
☐ High Cholesterol	_____
☐ Lupus	_____
☐ Mental Illness	_____
☐ Osteoporosis	_____
☐ Sleep Disorder	_____
☐ Stroke	_____
☐ Thyroid Disease	_____

Surgical History (check all that apply and date of surgery)

Surgery	Date of Surgery
☐ Appendectomy	_____
☐ Breast	_____
☐ Back / Neck	_____
☐ Gall Bladder	_____
☐ Hernia Repair	_____
☐ Heart	_____
☐ Hip, Knee, Shoulder	_____
☐ Hysterectomy	_____
☐ Lung	_____
☐ Tonsillectomy	_____
☐ _____	_____
☐ _____	_____

Social History (check all that apply)

- ☐ Never used any tobacco
- ☐ Former tobacco user.
- ☐ How long ago did you stop? _____
- ☐ Currently smoke.
- ☐ How much a day? _____
- ☐ How many years? _____
- ☐ Smokeless tobacco use (chewing tobacco, snuff, dip)
- ☐ How many years? _____
- ☐ Drink alcohol?
  How often? _____
  How much? _____

HEART OF TEXAS FAMILY MEDICINE

Patient Name: _____ Date of Birth: _____

Financial Policy and Signature on File

I authorize the release of any medical information to my primary care/referring physician, to consultants, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of benefits to *Heart of Texas Family Medicine*. I understand that I am financially responsible for all services rendered and for the following reasons: 1). I have given incorrect/invalid insurance information. 2) Expenses are not covered by my insurance company. 3) I have not met my deductible.
4). The services rendered are deemed medically unnecessary by my insurance company. (*This applies to present and future visits*). Payment is required for all services at the time they are rendered including co-payments and any out-standing balances. Your signature below signifies your understanding and willingness to comply with the policies of this office and your insurance plan.

X_____, _____, _____
Patient or Responsible Party Signature Phone No. Date

HIPPA COMPLIANCE STATEMENT

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
At *Heart of Texas Family Medicine,* we are committed to protecting your privacy. We comply with all federal, state, and local laws. This notice describes how we use your health information. It describes some of your rights and some of our responsibilities.

UNDERSTANDING YOUR HEALTH RECORD / INFORMATION

Each time you visit our offices, we record your symptoms, physical examination, test results, diagnosis, and treatment. This information enables us to: plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work, and improve the quality of our care.

YOUR RIGHTS

Although your paper chart belongs to our practice, the information contained in the chart is yours. You have the right to: inspect your records, obtain a copy of your chart, correct your records, and tell us not to release your information.

OUR RESPONSIBILITIES

We are required to: maintain the privacy of your health information; send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.

EXAMPLES OF HOW YOUR INFORMATION IS USED

Your health information will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Bills will be sent to your insurance company. The information in the bills will include confidential information such as your name, address, diagnosis, and treatment. In providing your care, we may communicate with other individuals or businesses. Examples include other physicians and/or laboratories. To protect your privacy, we ask our business associates to safeguard your information.

OTHER NOTICES

We may leave a message at your home, at your business, on your answering machine or on your voicemail. We may need to disclose your information to your family members or other people helping with your care. In doing so, we will use our best judgement. We may disclose information to others as required by law or if subpoenaed. We may, from time to time, update these policies.

X_____ _____
Patient or Responsible Party Signature Date