Dr. _____ **Patient Registration** Acct # _____

Patient
Name _____
(First) (Middle) (Last)

Address _____ City _____ State _____ Zip _____

Home # _____ Work # _____ Cell # _____

DOB _____ Age _____ Marital Status _____

Social Security # _____ Email _____

Employer Name _____ Occupation _____

Employer Address _____ City _____

Race _____ Language _____ Ethnicity _____

Please Notify in case of emergency _____ Phone # _____

Whom may we Thank for referring you? Primary Physician _____

SPOUSE/PARENT'S INFORMATION

Name _____ Name _____

Relationship to Parient _____ Relationship to Parient _____

SS# _____ DOB _____ SS# _____ DOB _____

Driver's License # _____ Driver's License # _____

Address _____ Address _____

Home Phone _____ Work _____ Home Phone _____ Work _____

Employer _____ Employer _____

INSURANCE INFORMATION IF NEW INSURANCE, PREVIOUS INSURANCE TERM DATE _____

Primary Insurance Co. _____ **Copay** _____ **Effective** _____

Address _____ Phone # _____

Certificate/ID # _____ Group/Plan # _____

Group/Employer Name _____

Insured's Name _____ DOB _____ Relationship to Patient _____

Secondary Insurance Co.

Address _____ Phone # _____

Certificate/ID # _____ Group/Plan # _____

Group/Employer Name _____

Insured's Name _____ DOB _____ Relationship to Patient _____

CONSENT TO TREATMENT: I hereby grant permission to the Physician in charge of my care and such Assistants as he or they may designate, to perform and administer all treatments and diagnosis, which in their judgement may be considered necessary or advisable for the patient's well being.

RELEASE OF INFORMATION: I hereby authorize Farmers Branch Primary Care LLC or Associate in charge of my care to release information contained in my medical records to the insurance company or companies, agents or independent contracts thereof, for the purpose of processing my claims for insurance benefits.

FINANCIAL AGREEMENTS: The undersigned hereby agrees that in consideration for services rendered, payment of the accounts is guaranteed in accordance to the regular rates and terms of Farmers Branch Primary Care LLC. The Undersigned clearly understands that payment obligation is the responsibility of the patient and or undersigned.

ASSIGNMENT OF BENEFITS: I hereby assign to Farmers Branch Primary Care LLC or Associate associated with my care and treatment any interest and benefits provided under my Insurance policy and policies. I also understand that any balance not covered by insurance are due and payable by myself.

_____ _____ _____

PATIENT OR REPRESENTATIVE RELATION WITNESS DATE

F RMERS BRANCH PRIMARY C E, LLC
NEW PATIENT QUESTIONNAIRE

NAME: _____ D.O.B. _____

OCCUPATION/EMPLOYER: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED SEPARATED

REFERRED BY: _____

PAST MEDICAL HISTORY

ALLERGIES: _____

CURRENT MEDICATIONS: _____

_____

HOSPITALIZATIONS: Please list any hospitalizations or surgeries excluding childbirth.

YEAR	REASON FOR HOSPITALIZATION
____	_____
____	_____
____	_____
____	_____

HEALTH HABITS: Please check habits you have.

____ SMOKING. Number of packs per day _____

____ ALCOHOL. Number of drinks per week. _____

____ STREET DRUGS. Describe _____

____ EXERCISE. Describe _____

PAST MEDICAL HISTORY AND FAMILY HISTORY

ILLNESS	PERSONAL	FAMILY
1. HEART DISEASE	____	____
2. HYPERTENSION	____	____
3. RESPIRATORY DISEASE	____	____
4. BREAST DISEASE/CANCER	____	____
5. JAUNDICE/HEPATITIS	____	____
6. GALL BLADDER DISEASE	____	____
7. HIATAL HERNIA/PEPTIC ULCER	____	____
8. BOWEL DISORDERS	____	____
9. KIDNEY DISEASE	____	____
10. URINARY INFECTIONS	____	____
11. URINARY INCONTINENCE	____	____
12. ANEMIA	____	____
13. BLOOD DISEASE	____	____
14. BLOOD TRANSFUSIONS	____	____
15. PHLEBITIS	____	____
16. THYROID DISEASE	____	____
17. DIABETES	____	____
18. CANCER	____	____
19. EPILEPSY/SEIZURES	____	____
20. NEUROLOGIC DISEASES	____	____
21. SKIN DISEASE/CANCER	____	____
22. TUBERCULOSIS	____	____
23. SEXUALLY TRANSMITTED DISEASE	____	____
GONORRHEA	____	____
CHLAMYDIA	____	____
SYPHILIS	____	____
HERPES	____	____
HIV	____	____
HPV/CONDYLOMA/WARTS	____	____

Adult Extended History Form

Patient Name: _____

Date of Birth: _____

Medical Record Number: _____

Date: _____

Past Medical History

☐ See Adult Summary Form

Past Surgical History

☐ See Adult Summary Form

Immunizations

☐ See Health Maintenance Flowsheet

Social History

Tobacco
☐ No
☐ Yes _____ppd x_____years

Stage
☐ Precontemplation
☐ Contemplation
☐ Action
☐ Consolidation
☐ Relapse

ETOH
☐ No
☐ Yes ____C ____A ____G ____E

Illicit Drug Use
☐ No ☐ Yes

Types/Quantity/Frequency
_____

Marital Status
☐ Single
☐ Married
☐ Civil Union
☐ Divorced
☐ Widow(er)

Children
☐ Boy(s) Age(s) _____
☐ Girl(s) Age(s) _____

Occupation(s)
_____

Religious Preference
_____

Advance Directive
☐ Yes ☐No
☐ No Interval Change
See Adult Summary Form

Nutritional/Exercise Assessment

Typical Breakfast
_____

Typical Lunch
_____

Typical Dinner
_____

Usual Snacks/Beverages
_____

Level of Activity (Exercise)
☐ None ☐ Occasional
☐ Regular ☐ Vigorous

Type of Exercise:
_____

Family History

Mother
☐ Alive, Age ____
☐ Deceased, Age ____ of _____

Father
☐ Alive, Age ____
☐ Deceased, Age ____ of _____

Sister(s)
☐ Alive, Age ____
☐ Deceased, Age ____ of _____
☐ Alive, Age ____
☐ Deceased, Age ____ of _____
☐ Others

Brother(s)
☐ Alive, Age ____
☐ Deceased, Age ____ of _____
☐ Alive, Age ____
☐ Deceased, Age ____ of _____
☐ Others

☐ No Interval Change;
See Adult Summary Form

Notes

Notes

_____

_____

_____

Signature _____ *Date* _____

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____.

OR

b. ☐ all past, present, and future periods.

3. Extent of Authorization

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. ☐ I authorize the release of my complete health record with the exception of the following information:

☐ Mental health records

☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol/drug abuse treatment

☐ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

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Date

Farmers Branch Primary Care, LLC

Acknowledgment of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practice, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Printed Name of Patient or Personal Representative	Date	Date of Birth
Signature of Patient or Personal Representative	Date	Date of Birth
Printed Name of Patient or Personal Representative	Date	Date of Birth
Description of Personal Representative's Authority	Date	Date of Birth

I, _____ give authorization to Farmers Branch Primary Care, LLC to release any information regarding my account/medical records to:

Name	Date	Date of Birth
Name	Date	Date of Birth
Name	Date	Date of Birth

Signed	Date	Witness	Date

I consent and authorize the release of any test results on my voice mail at my
___home ___cell ___work number