

PATIENT REGISTRATION

Today's Date: _____

Last Name: _____ First Name: _____ MI: _____

Mailing Address: _____

City: _____ State: Texas Other: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Age: _____ Date of Birth: _____ Sex: Female Male

Social Security Number: _____

Marital Status: Single Married Divorced Widowed Other: _____

Spouse's Name: _____

Consent to send statements and appointment reminders by email: Yes No

E-mail address: _____

Preferred Pharmacy: _____ Location: _____

Do you have a physician? Yes No If yes, Physician's Name: _____

EMPLOYMENT INFORMATION

Employment Status: Full-time Part-time Unemployed Retired Self-employed Student

Employer: _____

Address: _____

City: _____ State: Texas Other: _____ Zip Code: _____

Work Phone: _____ Extension: _____

Guarantor or Card Holder Information:

Last Name: _____ First Name: _____ MI: _____

Relationship to patient: _____

Social Security Number: _____

Date of Birth: _____

Cell Phone: _____

Mailing Address if different from above: _____

City: _____ State: Texas Other: _____ Zip Code: _____

PAYMENT INFORMATION

Do you have Insurance? Yes No Are you a self-pay patient? Yes No

How did you locate us or get our phone number: Phonebook Internet Other: _____

Person to notify in case of emergency: _____

Relationship: _____ Phone Number: _____ Cell Home Other

Name: _____ DOB: ____/____/____

Present Health Complaint: _____

Medication Allergies: _____

Ethnicity: _____ Preferred language/type of communication: _____

Learning style: Verbal Visual Written Other: _____

Medical History: (Please indicate if you have EVER had any of the following)

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergies (hay fever, etc.) | <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Loss or Gain in Weight |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Frequent Colds/Pneumonia | <input type="checkbox"/> Malaria |
| <input type="checkbox"/> Asthma or Hay Fever | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Bladder Trouble/Disease | <input type="checkbox"/> Goiter or Thyroid Trouble | <input type="checkbox"/> Myalgias (Muscle Pain) |
| <input type="checkbox"/> Bursitis or Shoulder Pain | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Nervous or Mental Disorder |
| <input type="checkbox"/> Cancer, Cysts, Tumors | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Pain in Arms or Hands |
| <input type="checkbox"/> Change in Bowel Habits | <input type="checkbox"/> Hepatitis or Cirrhosis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Chest Pain or Pressure | <input type="checkbox"/> Herpes Simplex | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Chicken Pox (Varicella) | <input type="checkbox"/> High or Low Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Chronic Cough/Bronchitis | <input type="checkbox"/> Indigestion/Heart Burn/Stomach | <input type="checkbox"/> Swelling of Ankles/Feet |
| <input type="checkbox"/> Dermatitis/Skin Rashes | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Swollen Joints |
| <input type="checkbox"/> Diabetes/Low Blood Sugar | <input type="checkbox"/> Joint Pain / Arthritis | <input type="checkbox"/> Tuberculosis/ + Skin Test |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Kidney Problems/Disease | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Latex Allergies | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Liver Disease or Jaundice | <input type="checkbox"/> Wrist or Elbow Pain |
| <input type="checkbox"/> COPD / Emphysema | | |

Family History: (Please indicate if applicable)

- | | | |
|---|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Lung Disease | |

Social History: (Please indicate if applicable)

- Married Single Widow Divorced Other
- Exercise: _____ times / per week Smoker _____ packs / per day _____ yrs Alcohol _____ drinks / per day
- Unusual Stress: _____

Have you ever been hospitalized? No Yes: IF Yes, Please list: _____

Have you ever had surgery? No Yes: IF Yes, Please list: _____

Females Only: (Please indicate if applicable)

- | | | |
|--|---|---|
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Post-Menopausal | <input type="checkbox"/> Irregular Menstrual Periods |
| <input type="checkbox"/> Painful Menstrual Periods | <input type="checkbox"/> Bleeding/Spotting after Sex | <input type="checkbox"/> Painful Intercourse |
| <input type="checkbox"/> Multiple Sexual Partners | <input type="checkbox"/> Abnormal Pap Smear | <input type="checkbox"/> Last Pap Smear: ____/____/____ |
| <input type="checkbox"/> Abnormal Breast Exam | <input type="checkbox"/> Last Mammogram: ____/____/____ | <input type="checkbox"/> Previous Pregnancies: _____ |
| <input type="checkbox"/> Miscarried or Abortion: _____ | <input type="checkbox"/> Last Normal Menstrual Period: ____/____/____ | |
| <input type="checkbox"/> Pregnant or Possibility of being Pregnant Now <input type="checkbox"/> Current Contraception: _____ | | |

Males Only: (Please indicate if applicable)

- | | | |
|---|---|---|
| <input type="checkbox"/> Prostate Trouble | <input type="checkbox"/> Abnormal Testicular Exam | <input type="checkbox"/> Urethral Discharge |
| <input type="checkbox"/> ALWAYS uses Condoms | <input type="checkbox"/> Multiple Sexual Partners | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Number of Children fathered: _____ | | |

(Signature of Patient)

(Date)

MEDICATION SHEET

Today's Date:

Pharmacy:

Drug Food Allergies/Reactions:

Please list your medications/herbs/vitamins below or indicate you have a list for the staff to photocopy, and give to the receptionist. Provided for the staff to photocopy.

<i>Medication/Herbal/ Vitamin Name "Please Print"</i>	<i>Dosage/ Strength</i>	<i>Route – How do you take? Example: By Mouth</i>	<i>Frequency – How often do you take? Example: Twice a day</i>	<i>Last time you took medication?</i>

Person completing the list: _____ Date: _____

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Chart Copy

MEDICATION SHEET



Patient Name: _____ DOB: _____

I understand that as part of my health care, Brazosport Regional Family Medicine Center originates, records and maintains protected health information about me describing my health history, symptoms, examination and test results, diagnoses, treatment, and plans for future care or treatment. I understand that this protected health information may be used and disclosed by Brazosport Regional Family Medicine Center for treatment, payment and health care operations. For example, my protected health information serves as:

- A basis for planning my care and treatment;
- A means of communication among the many health professionals who contribute to my care;
- A source of information for applying my diagnosis to my bill;
- A means by which a third-party payer can verify that services billed were actually provided; and
- A tool for routine health care operations, such as assessing quality and reviewing the competence of health care professionals.

I acknowledge that I have been provided with Brazosport Regional Family Medicine Center’s Notice of Privacy Practices that provides me a more complete description of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that Brazosport Regional Family Medicine Center reserves the right to change its Notice of Privacy Practices and a revised copy will be given to me at my next visit at Brazosport Regional Family Medicine Center. Initial: _____ Date received: _____

I understand that I have the right to request restrictions as to how my protected health information may be disclosed to carry out treatment, payment or health care operations. Brazosport Regional Family Medicine Center is not required to agree to the restrictions as requested, but if it does, it is bound by such restrictions.

I understand that I may revoke this consent in writing, except to the extent that Brazosport Regional Family Medicine Center has already taken action in reliance thereon.

By signing this form, I consent to Brazosport Regional Family Medicine Center’s use and disclosure of my protected health information for treatment, payment and health care operations.

Patient Name (Please Print): _____ Date: _____

Signature of Patient/Legal Representative: _____ Date: _____

Witness: _____ Date: _____

Notice Effective Date: _____

CONSENT TO MEDICAL TREATMENT

I, (for) the undersigned patient, do hereby voluntarily consent to such care involving routine diagnostic procedures and medical treatment by Brazosport Regional Family Medicine Center. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of any treatment or examinations to be rendered during this visit.

Patient Name (Please Print): _____ Date: _____

Signature of Patient/Legal Representative: _____ Date: _____

Witness: _____ Date: _____

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PATIENT CONSENT FOR USE AND DISCLOSE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS AND CONSENT TO MEDICAL TREATMENT



Patient Name: _____ DOB: _____

PATIENT RIGHTS

EVERY PATIENT SHALL HAVE THE RIGHT TO:

- Reasonable access to care
- Receive considerate and respectful care
- Visitors
- Know the name of his/her physician
- Be informed of his/her health condition, including unanticipated outcomes
- Information Concerning: Diagnosis, Treatment, Prognosis
- Be involved in care planning and treatment
- Formulate advance directives and appoint a surrogate to make health care decisions on his/her behalf to the extent permitted by law
- Accept or refuse treatment and be informed of the medical consequences of such refusal
- Make informed decisions regarding participation in clinical research
- Personal respect, privacy and confidentiality
- Access to information contained in his/her clinical or medical records within a reasonable timeframe
- Confidentiality of clinical and medical records
- Social, religious, and psychological well being
- Reasonable response to requests for service including ethical issues
- A qualified interpreter if needed
- Be informed of Clinic rules, regulations, and complaint resolution
- Knowledge concerning the professional status of caregivers
- Access protective services
- Appropriate assessment and management of pain
- To receive treatment and care in the least restrictive environment
- Receive care in a safe setting and be free from abuse or harassment
- Explanation of his/her bill and access to financial counsel

PATIENT RESPONSIBILITIES

EVERY PATIENT IS RESPONSIBLE FOR:

- Communicating honestly and directly
- Cooperating with the health care team
- Understanding his/her health issues
- Participating in his/her medical plan
- Consequences resulting from non-compliance
- Being respectful of others and Clinic property
- Informing the Clinic of a violation of patients rights
- Fulfilling his/her financial obligations for health care
- Communicating any safety concerns including perceived risks in his/her care, and unexpected change(s) in their condition

COMPLAINTS AND GRIEVANCES

If you have a concern regarding any aspect of your care, please ask to speak with the supervisor or director/manager responsible for the area of concern. If you feel that your concern was not adequately addressed, please call the Hospital Administration at 979-285-1825 or extension 1825. After hours dial "0" for the operator who will page the Administrator on call. If your complaint continues to be unresolved, you may also call the Texas Department of Human Services 800-228-1570; Texas State Board of Medical Examiners 800-201-9353; Texas Dept of Protective and Regulatory Services 800-252-5400; Medicare Beneficiary Hot Line 800-725-8315. Concerns regarding safety and quality of care issues may be reported to The Joint Commission 800-994-6610. E-mail complaint @jointcommission.org.

Patient's Signature _____ Date _____

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PATIENT RIGHTS

