Friendswood Family Medicine Patient Registration

Patient Information

First Name	Last Name	MI	Date of Birth
Address	City	State	Zip

Please check Primary phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐
Other Name(s) Used		E-mail Address	
Gender ☐ M ☐ F	SSN	Preferred Language	Driver's License

Marital Status	Preferred Contact	Ethnicity	Race
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner	☐ Mail ☐ Home Phone ☐ Day Phone ☐ Cell Phone ☐ Patient Portal	☐ Hispanic/Latino ☐ Non-Hispanic	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other

Primary Care Provider	Referring Provider

Responsible Party (Guarantor) ☐ Same as patient

First Name	Last Name	MI	Date of Birth
Address	City	State	Zip

Please check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐
SSN	Relationship to Patient	Preferred Language	Driver's License

Emergency Contact (for minor child, this section may be used for other parent)

First Name	Last Name	MI	Date of Birth
Address	City	State	Zip

Please check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

I/We do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physicians and staff of Friendswood Family Medicine to me or to the above named minor to whom I am the parent or legal guardian. I hereby certify to the best of my knowledge, all statements contained herein are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage, excluding only authorized services provided under a valid prepaid HMO contract. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize Friendswood Family Medicine to release information requested by my insurance company and/or its representatives. I fully understand this agreement and consent will continue until canceled by me in writing.

Signature of Patient/Responsible Party _____ Date _____

Name of Patient/Responsible Party (Please Print) _____ Relationship to Patient _____

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Pharmacy Information	
Preferred Pharmacy	Secondary Pharmacy
Name	Name
Address	Address
Phone	Phone
Fax	Fax

Advanced Directives

☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐ Living Will ☐ HC Proxy

Date Reviewed:

Medications – List all medications you take, prescription and non-prescription, and the dosage

☐ I do not take any medications

Medication Name	Dosage

Medication and Food Allergies – List all known allergies (drugs, food, animals, etc.)

☐ No Known Allergies

Medical History – Check if you have ever experienced the following conditions, and year of onset.

Condition	Year	Condition	Year
☐ None		☐ Gallbladder Disease	
☐ Allergies		☐ GERD (Reflux)	
☐ Anemia		☐ Hepatitis C	
☐ Angina		☐ Hyperlipidemia	
☐ Anxiety		☐ Hypertension	
☐ Arthritis		☐ Irritable Bowel Disease	
☐ Asthma		☐ Liver Disease	
☐ Atrial Fibrillation		☐ Migraine Headaches	
☐ Benign Prostatic Hypertrophy		☐ Myocardial Infarction	
☐ Blood Clots		☐ Osteoarthritis	
☐ Cancer – Type		☐ Osteoporosis	
☐ Cerebrovascular Accident		☐ Peptic Ulcer Disease	
☐ Coronary Artery Disease		☐ Renal Disease	
☐ COPD (Emphysema)		☐ Seizure Disorder	
☐ Crohn's Disease		☐ Thyroid Disease	
☐ Depression		☐ Other	
☐ Diabetes		☐ Other	

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Surgical History – Check if you have received the following procedures, and year performed.			
Surgical Procedure	Year	Surgical Procedures	Year
☐ None		Male Only	
☐ Angioplasty		☐ Prostate Biopsy	
☐ Angioplasty w/Stent		☐ TURP (Trans-urethral resection of Prostate)	
☐ Appendectomy			
☐ Arthroscopy Knee		☐ Vasectomy	
☐ Back Surgery		☐ Other	
☐ CABG (heart bypass)		☐ Other	
☐ Carpal Tunnel Release			
☐ Cataract Extraction		Female Only	
☐ Cholecystectomy		☐ Augmentation Mammoplasty	
☐ Colectomy		☐ Bilateral Tubal Ligation	
☐ Colostomy		☐ Breast Biopsy	
☐ Gastric Bypass		☐ Cesarean Section	
☐ Hernia Repair		☐ D and C	
☐ Hip Replacement		☐ Hysterectomy	
☐ Knee Replacement		☐ Mastectomy	
☐ LASIK		☐ Myomectomy	
☐ Liver Biopsy		☐ Reduction Mammoplasty	
☐ Pacemaker		☐ TAH/BSO	
☐ Small Bowel Resection		☐ Vaginal Hysterectomy	
☐ Thyroidectomy		☐ Other	
☐ Tonsillectomy		☐ Other	

Health Maintenance – Check if you have received the following, and date of most recent exam.			
Exam	Date	Exam	Date
☐ None		☐ GYN Exam	
☐ Breast Exam		☐ Influenza Vaccine	
☐ Cardiac Stress Test		☐ Lipid Panel	
☐ Colonoscopy		☐ Mammogram	
☐ DEXA Scan		☐ PAP Test	
☐ Echocardiogram		☐ Physical Exam	
☐ EKG		☐ Pneumococcal Vaccine	
☐ Eye Exam		☐ Pulmonary Function Test	
☐ FOBT (stool card for hidden blood)		☐ Sigmoidoscopy	
☐ Foot Exam		☐ Tetanus Vaccine	

Family History – Check if any family member(s) has had any of the following conditions.

☐ Adopted

Diagnosis	Mother	Father	Sibling	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcoholism/Drug Dependence	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐
Alzheimer's Disease	☐	☐	☐	☐	☐	☐	☐
Lung Disease/Asthma/COPD	☐	☐	☐	☐	☐	☐	☐
Blood Disease/Anemia/Leukemia	☐	☐	☐	☐	☐	☐	☐
CAD (Heart Disease)	☐	☐	☐	☐	☐	☐	☐
Cancer – Type:	☐	☐	☐	☐	☐	☐	☐
Stroke/TIA	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐

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Family History – continued

Diagnosis	Mother	Father	Siblings	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Eczema	☐	☐	☐	☐	☐	☐	☐
Hearing Deficiency	☐	☐	☐	☐	☐	☐	☐
Hyperlipidemia (High Cholesterol)	☐	☐	☐	☐	☐	☐	☐
Hypertension (High Blood Pressure)	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Disease	☐	☐	☐	☐	☐	☐	☐
Ulcers/GERD	☐	☐	☐	☐	☐	☐	☐
Mental Illness/Depression/Anxiety	☐	☐	☐	☐	☐	☐	☐
Headaches/Migraines	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
Varicose Veins	☐	☐	☐	☐	☐	☐	☐
Seizures/Epilepsy	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐

Social History for Adult Patient

Occupation	Employer	
Do you have children? ☐ Yes ☐ No	How many?	Female(s) / Male(s)
Tobacco Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year quit:	☐ Chewing ☐ Pipe ☐ Cigar ☐ Cigarette ☐ Smokeless Brand:
Alcohol Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year quit:	☐ Beer ☐ Wine ☐ Liquor ☐ Other:
Exercise Activity	☐ Moderate ☐ Vigorous ☐ Sedentary Days/Week:	Sleep Pattern ☐ Changes ☐ No Changes
Caffeine Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year quit:	☐ Chocolate ☐ Coffee ☐ Soda ☐ Tea ☐ Tablets ☐ Other:

For Pediatric Patient

Patient Resides with	Primary	☐ Mother	☐ Father	☐ Both Parents	☐ Other:
	Secondary	☐ Mother	☐ Father	☐ Other:	

Mother's Occupation	Father's Occupation
Parents Relationship ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed	Childcare ☐ Mother ☐ Grandparent ☐ Father ☐ Nanny ☐ Sibling ☐ Daycare
Tobacco Exposure ☐ Yes ☐ No Smokers at home ☐ Yes ☐ No	Patient is current smoker? ☐ Yes ☐ No Packs per day:

Friendswood Family Medicine

Assignment of Insurance Benefits/Eligibility Certification

Primary Insurance Plan		
Patient Name	Date of Birth	
Insurance Plan	Group #	Policy #
Insurance Company Address	Phone #	
Subscriber Name	Relationship to Patient	
Subscriber Certificate/Social Security #	Subscriber Date of Birth	
Subscriber Employer	Employer Phone #	
Employer Address		

For Medicare Patients Only		
Health Insurance Claim #	Part A Effective Date	Part B Effective Date

Other Insurance Coverage for Patient		
Patient Name	Date of Birth	
Insurance Plan	Group #	Policy #
Insurance Company Address	Phone #	
Subscriber Name	Relationship to Patient	
Subscriber Certificate/Social Security #	Subscriber Date of Birth	
Subscriber Employer	Employer Phone #	
Employer Address		

I hereby authorize and request that payment of authorized Medicare/other insurance company benefits be made on my behalf, be paid directly to Friendswood Family Medicine for any medical or surgical services rendered by its affiliated medical groups to me or a member of my family. I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its agents or carriers, or the insurance company any information needed for this or a related Medicare/other insurance claim to determine these benefits or the benefits payable for related services. I understand that it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment.

I understand that I am eligible for benefits through my HMO policy. I understand that my assigned IPA/Medical Group chosen for my benefits is a Friendswood Family Medicine affiliated medial group.

I am aware that if the above is not true, I (or the person financially responsible for me) am responsible for all charges related to services provided to me.

I agree that if the above is not true, I (or the person financially responsible for me), will pay in full all such charges.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient

Friendswood Family Medicine

Communicating with You

In order to effectively communicate with you about your medical information we request that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate test results, prescription information or respond to a message you left for our office. We may communicate with you through mail, secure email, telephone and your secure patient portal, including leaving messages on your answering machine/voicemail.

Please check all boxes that you give Friendswood Family Medicine permission to use for your communications:

☐ You may contact me by telephone	Phone Number:_____
☐ You may leave a message/voicemail	Phone Number:_____
☐ You may contact me by mail/email	Email:_____
☐ You may contact me through my patient portal	

If you give permission for us to communicate with anyone else, please complete the list below:

Name/Phone number	Relationship	Options
1.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information
2.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information
3.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information
4.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information

This request supersedes any prior request for communication of information I may have made.

_____ _____

Printed Name of Patient/ Responsible Party Date

_____ _____

Signature of Patient/Responsible Party Relationship to Patient

Friendswood Family Medicine

ACKNOWLEDGEMENT OF RECEIPT Joint
Notice of Privacy Practices

Your name and signature on this form indicates that you have received a copy of Friendswood Family Medicine *Joint Notice of Privacy Practices* on the date and time indicated below.

If you have any questions regarding the information contained in Friendswood Family Medicine

Joint Notice of Privacy Practices, please don't hesitate to ask.

Printed Name: _____

Signature: _____

Relationship to Patient: _____

Date Received: _____ Time Received: _____

FOR FACILITY USE ONLY

We attempted to obtain written acknowledgement of patient's receipt of our *Joint Notice of Privacy Practices*, but acknowledgement could not be obtained from the patient for the following reason:

- ○ Individual Refused to Sign
- ○ Emergency Situation Prevented Signature
- ○ Patient Requested Above Individual Sign on His/Her Behalf
- ○ Other (please specify)

_____

Registration Representative Signature: _____ Date: _____

Friendswood Family Medicine

Office Policies and Information

Monday – Friday 7:00am-4:00pm

Late or Missed Appointments: If you are unable to keep your appointment, please call the office 24 hours prior to your visit so we may fill the appointment space. If you arrive late for your appointment you may be asked to reschedule or be worked in at a later time depending on our schedule availability. If you simply do not show up for your appointment, you will be billed a **$25.00** no-show fee.

Clinic Notes: **We do not accept walk in appointments.** Please call in medication refills 48 hours in advance (please **do not** wait until you have taken your last pill). Some medication refills may require an appointment to be seen by the physician. Certain medications may require pre-authorization from your insurance company and this process can take up to 72 hours. **If you LOSE your prescription you will have to make an appointment for another prescription and pay another office visit.** Please allow adequate time for a return phone call. Messages taken after 3:00pm may not be returned until the next business day. Anyone under the age of **18** must be accompanied by an adult to receive medical treatment or have written permission by a parent.

Referrals & Authorizations: Certain insurance plans require a referral authorization from your Primary Care Physician prior to treatment from a specialist and/or facility. This process can take anywhere from 48-72 hours. Once the authorization is obtained the referral will be mailed to you.

Medication Prior Authorization: There may be times when you are prescribed a medication that is not on your insurance plans formulary or is not covered by your plan. If your medication requires a prior authorization this process takes 48-72 hours on average. Please be aware that there are other factors that may delay this process.

Co-payments & Deductibles: Co-payments are amounts that you have agreed to pay at each office visit with your insurance company. Many insurance plans also require an annual deductible amount that is your responsibility. Payment for co-pays or deductibles is due at the time of your appointment. We accept cash, credit cards or debit cards for payment. Please check with your insurance carrier to determine whether you have a co-pay or are required to meet a deductible.

You acknowledge full responsibility for the payment of such services and agree to pay at the time of service. You also, understand that insurance coverage is an arrangement between you and your carrier. We will bill your insurance company as a courtesy, **but you are ultimately responsible for payment should your insurance fail to pay within 90 days.** It is your responsibility to inform us of any changes in your insurance, telephone numbers and address. Insurance companies give us 90 days to file a claim, therefore, if we bill the wrong carrier because you failed to provide the correct information the office visit will be your responsibility. We understand that temporary financial problems may affect timely payment of your balance and we encourage you to communicate such problems to us so that your account can be properly managed.

Policy: We reserve the right to cancel your care due to conduct, non-cooperation or non-payment. You will be given notice legally dismissing you from our practice and be asked to find another physician.

I have read and understand the Office Policies of Friendswood Family Medicine

_____

Printed Name of Patient

_____ _____

Patient or Guardian Signature Date

Authorization to Release Medical Records

Patient Name:_____ Date of Birth:_____

Address: _____Social Security# _____

City:_____ State:_____ Zip Code: _____

I hereby authorize the release of medical information FROM:

_____

_____

_____

To be released TO:

Friendswood Family Medicine
300 East Edgewood
Friendswood, TX 77546
Phone: 281-485-9034Fax: 281-485-9807

Check all that my be released:

Complete Records ☐	History ☐	Physical ☐	Progress Notes ☐
Lab Reports ☐	X-Rays ☐	EKG Report ☐	Operative Reports ☐
Psychological Reports ☐	Therapy Reports ☐	Care Plan ☐	Discharge Summary ☐
Other: ☐			

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

This authorization covers care provided from _____to _____.

Purpose of disclosure:

☐ Medical Care ☐ Employer ☐ Insurance
☐ Attorney ☐ Other: _____

This authorization is valid for 180 days from the date of signature. Consent for authorization may be revoked at anytime in writing prior to the expiration date except to the extent disclosure made in good faith has already occurred in reliance on the consent. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and is no longer protected by this rule.

Date: _____

Signed: _____
Patient or Representative

_____
Relationship to Patient