WOODLANDS FAMILY MEDICINE CLINIC

REGISTRATION FORM

(Please Print)

Today's date:	**PCP:**

PATIENT INFORMATION

Patient's last name: **First:** **Middle:**				**Marital status:**
Is this your legal name? ❑ Yes ❑ No	**If not, what is your legal name?**	**Former name:**	**Birth date:** / /	**Sex:** ❑ Male ❑ Female
Street address, City, State, Zip:		**Social Security #:**		**Home phone #:** ( )
P.O. box, City, State, Zip:				
Occupation:	**Employer:**		**Employer phone #:** ( )	
Who may we thank for referring you to our clinic? **Name:** **Phone #:**				
Please list any other family members seen here:				
Email Address:				

RESPONSIBLE PARTY INFORMATION

Person responsible for bill:	**Birth date:** / /	**Address (if different than patient):**	**Home phone #:** ( )
Is this person a patient here? ❑ Yes ❑ No			

PRIMARY INSURANCE INFORMATION

(Please give your insurance card and Driver's license or State ID to the receptionist with completed paperwork)

Is this patient covered by insurance? ❑ Yes ❑ No **Insurance company name:**				
Insurance claims address:				
Insurance phone #:				
Subscriber/ Policy holder name:	**Subscriber Social security #**	**Subscriber Birth date:** / /	**ID/Policy #:**	**Group #:**
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:				

SECONDARY INSURANCE INFORMATION

Secondary Insurance name & phone #:	**Subscriber/ Policy holder name:**	**Subscriber Birth Date:** / /	**ID/Policy #:**
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:			**Group #:**

IN CASE OF EMERGENCY

Name of local friend or relative:	**Relationship to patient:**	**Home phone #:** ( )	**Work phone #:** ( )

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 Family Medicine Clinic & Women's Health or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature ***Date***

WOODLANDS
FAMILY MEDICINE CLINIC

MEDICAL HISTORY

DATE: _____

PATIENT NAME: _____

ARE YOU EMPLOYED? YES ☐ NO ☐ TYPE OF WORK: _____

MARITAL STATUS

SINGLE ☐ MARRIED ☐ SEPERATED ☐ DIVORCED ☐

NAME OF SPOUSE: _____

PREVIOUS SURGERIES: (NAME & DATE)

_____

_____

MAJOR ILLNESSES OR INJURIES:

_____ _____

_____

FAMILY HISTORY	*AGE IF LIVING*	*AGE OF DEATH*	*PRESENT CONDITION OR CAUSE OF DEATH*
FATHER			
MOTHER			
BROTHER(S)			
SISTER (S)			
CHILDREN			

PLEASE INDICATE IF A PARENT, BROTHER OR SISTER HAS EVER HAD ANY OF THE FOLLOWING:

☐**ARTHRITIS** ☐ **ASTHMA** ☐**BREAST CANCER** ☐ **COLON CANCER** ☐ **COLON POLYPS**

☐**TUBERCULOSIS** ☐**DIABETES** ☐ **THYROID ISSUES** ☐**HIGH CHOLESTEROL** ☐**STOMACH ULCERS**

☐ **HIGH BLOOD PRESSURE** ☐ **STROKE** ☐**HEART TROUBLE**

WHEN WAS YOUR LAST TETANUS SHOT? _____

CURRENT HEIGHT: _____ **CURRENT WEIGHT:** _____

HAVE YOU EVER SMOKED? YES ☐ NO ☐ IF YES, HOW MUCH_____

DO YOU DRINK ALCOHOL? YES ☐ NO ☐ IF YES, HOW MUCH_____

HAVE YOU EVER USED RECREATIONAL DRUGS? YES ☐ NO ☐

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NURSE PRACTITIONER CONSENT

This facility has on staff Nurse Practitioners to assist in the delivery of medical (Family Practice Specialty) care.

A Nurse Practitioner is not a doctor. A nurse Practitioner is a Registered Nurse who has received advanced education and training in the provision of healthcare. A Nurse Practitioner can diagnose, treat and monitor common illnesses and chronic diseases as well as provide health maintenance care. In addition, the Nurse Practitioner may treat minor lacerations and other minor injuries.

I have read the above and herby consent to the services of a Nurse Practitioner for my healthcare needs.
I understand that at any time I can refuse to see the Nurse Practitioner and request to see a Physician.

Patient Signature: _____ Date: _____

Physician Financial Disclosure Notification

Hazem Elzufari MD PA has a financial investment in Aspire Hospital, Woodlands Vascular Access and Baylor CHI St Luke`s Freestanding Emergency Centers.

Patient Initials: _____ Date: _____

NOTICE OF PRIVACY PRACTICE/HIPPA

Family Medicine Clinic and Women's Health has provided a copy of their HIPPA and Privacy Practice Notification for review and will provide a copy at your request.

Patient Initials: _____ Date: _____

No-Show Policy

Family Medicine Clinic and Women's Health imposes the following policy with regard to patients who fail to keep their scheduled appointments. Patients who fail to come in for their scheduled appointment or do not contact our office to cancel or reschedule their appointment at least 24 hours prior to their scheduled appointment time, shall be subject to a **"No Show" penalty of $25.00. Insurance plans will not cover charges for No Show fees**. No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

Medicaid: If a patient has Medicaid and no-shows in our office 3 times the **patient will be terminated from our practice** and will no longer be able to make any future appointments in our office.

By signing below you are acknowledging that you have read and understand the above information.

Patient Signature: _____ Date: _____

Schedule II Prescriptions

Due to increased work load and time spent processing prescriptions, as of November 6,2014 we will charge a $10.00 processing fee for **ALL CII prescriptions** that have to be written and picked up at the office. This **will not** be billed to your insurance. The money will be due when the prescription is picked up. (Per state regulations: Medicaid and workers compensation patients are excluded)

Patient Signature: _____ Date: _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #:_____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

This request and authorization applies to:

☐ Yes ☐ No Healthcare information relating to the following treatment, condition, or dates:

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by las, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the relapse of any records regarding drug, alcohol or mental health treatment to the person(s) listed above.

Patient/Guardian Signature: _____ Date Signed: _____

Guardian's printed name _____ Relationship to patient _____ _____

THIS AUTHORIZATION EXPIRES AFTER NINETY DAYS