TexomaCare: Patient Registration / Informacion Sobre El/La Paciente

PATIENT INFORMATION / INFORMACION PACIENTE

Patient: Last, first name and middle initial / Garantizador: Apellido, Nombre			Date of Birth Fecha de Nacimiento
Social Security Number / Numero de Seguro Social	Marital Status / Estado Civil	Sex / Sexo	Home Telephone# / Numero de Telefono email: _____
Physical Address / Direccion: Numero Calle Cuidad Estado Zono Postal			
Mailing Address, if different from Physical Address / Otro Direccion			
Employer / Patron De Garantizador			Employer's Telephone # Numero de Telefono del Patron de Garantizador

FINANCIAL INFORMATION, Part I / INFORMACION DEL PACIENTE I

***Responsible party if other than patient**: Last, first name and middle initial / Paciente: Apellido, Nombre *this person would be responsible and receive the bills after insurance responded			Date of Birth Fecha de Nacimiento
Social Security Number / Numero de Seguro Social	Marital Status / Estado Civil	Sex / Sexo	Home Telephone# / Numero de Telefono
Mailing Address, if different from Patient / Direccion: si es Differente de el Garantizador			Relationship to Guarantor Relacion at Garantizador

RELEASE OF INFORMATION-PLEASE LIST ALL PERSONS AUTHORIZED TO OBTAIN MEDICAL/FINANCIAL INFO

Last, first name and middle initial / Apellido, Nombre	Relationship:
Last, first name and middle initial / Apellido, Nombre	Relationship:
Last, first name and middle initial / Apellido, Nombre	Relationship:
Last, first name and middle initial / Apellido, Nombre	Relationship:

PATIENT INFORMATION, Part II (if applicable)/ INFORMACION SOBRE EL PACIENTE (si es aplicable)

Patient's Employer / Patron de Paciente	

EMERGENCY CONTACT / EN CASO DE EMERGENCIA

Emergency Contact / En caso de Emergencia Llama	Emergency Contact's Telephone # / Numero de Telefono

Referring Physician:

Family Physician:

Pharmacy preference: **CITY:**

Do you want to be Web Enabled?: ❑ **Yes** ❑ **No** **email address:**

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INSURANCE INFORMATION / INFORMACION SOBRE ASEGURANCIA

Primary Insurance **Nombre de la Compania de Asegurancia Primario**	ID or Policy # / Numero de Poliza	Phone # / El teléfono #	Group # / Numero de Grupo
Subscriber's Name (who owns the policy) Nombre de Suscriptor	Date of Birth Fecha de Nacimiento	Employer / Patron de Suscriptor	Effective Date Fecha de Valido
Secondary Insurance **Nombre de la Compania de Asegurancia Secundario**	ID or Policy # / Numero de Poliza	Phone # / El teléfono #	Group # / Numero de Grupo
Subscriber's Name (who owns the policy) Nombre de Suscriptor	Date of Birth Fecha de Nacimiento	Employer / Patron de Suscriptor	Effective Date Fecha de Valido

CONSENT FOR TREATMENT AND UNDERSTANDING OF FINANCIAL RESPONSIBILITY
MEDICAL PERMISCO para TRATAMIENTO y RESPONSIBLE de PAGOS

The patient agrees to general medical treatment by TexomaCare physicians and understands and consents to the review and use of his/her medical records by any TexomaCare physician. All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. However, it is understood and agreed to that the patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.
Deside usted que le van a dar tratamiento medico general, por los doctores de TexomaCare y consultar con ostros doctores de TexomaCare. Todos los servicias son la responsabilidad de usted. Lienamos las formas para cobrar a su asegurancia, pero usted es responsable por los cobros. Es costumbre pagar por servicios el mismo dia o tal vez si a hecho otros arregralmentos antes de la cita.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS
PERMISO para ASEGURANCIA y BENIFICCIOS

I hereby authorize TexomaCare to furnish information concerning my medical condition and treatment thereof to insurance carriers. I also assign insurance benefits paid on my behalf by any and all insurance companies that cover the expenses I incur as the result of any diagnostic services or treatment provided to me by any TexomaCare physician. I further agree that this authorization to release information and assignment of benefits shall remain in effect unless and until it is revoked in writing by me.

➔**Signature of patient / legal representative:**

HIPAA – NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you and/or spouse/children may be used and disclosed and how you can get access to this information. I acknowledge that the TexomaCare Notice of Privacy Practices has been provided.

➔**Signature of patient / legal representative**:

PARENTAL AUTHORIZATION FOR TREATMENT OF A MINOR

The authorization form is to give consent to someone(s) other than a parent/legal guardian for the medical treatment of the patient for any unhealthy condition or well visits.

➔**Signature of Parent , Patient or Head of Household** / Garantizador: Apelido, Nombre	**Date** / Fecha de Firma

OFFICE USE

Data Collected by Whom:	Date of Data Collection:	Data Entered by Whom	Date of Data Entered:

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PATIENT INFORMATION

TEXOMACARE

CHART NO: _____

DATE: _____

PATIENT'S PERSONAL HISTORY

Patient Demographics Updated: _____ Confidential Record: Information will not be released without authorization.

Last Name	First Name	Middle Initial	Birth Date	Birth Place

Occupation: _____ Employer: _____ Employer's Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Date of Last Physical Exam: _____ Doctor: _____

Family or Referring Physician: _____

Reason for Visit: _____

_____

DRUG ALLERGIES: _____

Family History			**If Living**		**If Deceased**	
			Age	Health	Age at Death	Cause
Father						
Mother						
Brothers/Sisters	Sex		Age	Health	Age at Death	Cause
	M	F				
	M	F				
	M	F				
	M	F				
Sons/Daughters	Sex		Age	Health	Age at Death	Cause
	M	F				
	M	F				
	M	F				
	M	F				

Immunizations Current: ☐ Yes ☐ No Dates of Last Tetanus: _____ Last Flu: _____ Last Pneumonia: _____

Do you know of any **BLOOD RELATIVE** who has had: (Circle and give relationship.)

Stroke: _____ High Blood Pressure: _____

Cancer: _____ Thyroid Problem or Goiter: _____

Heart Attack: _____ Bleeding Disorder: _____

Diabetes: _____ Tuberculosis: _____

Kidney Disease: _____

Personal Habits: (Circle yes or no.)

Yes No Do you use tobacco? What kind? _____ For how many years? _____

Yes No Do you drink alcohol? What kind? _____ How often? _____

Yes No Do you use any street drugs? What kind? _____ How often? _____

List all medications you take and the dose: _____

_____

_____

Please complete the back page of this form.

Write in the names and year of any operations you have had:

Hysterectomy: _____ Other: _____

Heart Surgery: _____

Abdominal Surgery: _____

Cancer Surgery: _____

Circle or write in the names of chronic medical problems you have had and for how long:

Diabetes High Blood Pressure Kidney Disease Lung Disease Heart Disease Cancer

Other: _____

Women Only	Men Only
Are you having regular periods? _____	Have you had prostate problems? _____
Date of last period? _____	_____
How many pregnancies? _____	Have you had any hernias? _____
Date of last pap smear: _____	_____
Have you had an abnormal pap smear? _____	Date of last PSA test: _____
Date of last mammogram: _____	_____

Review of Systems: (Circle yes or no and explain.)

Yes	No	Any fevers, sweats, or weight change?	_____
Yes	No	Any stomach or bowel complaints?	_____
Yes	No	Any headaches, dizzy spells, or weakness?	_____
Yes	No	Any problems with eyes?	_____
Yes	No	Any problems with ears, nose, or throat?	_____
Yes	No	Any chest pain?	_____
Yes	No	Any shortness of breath or cough?	_____
Yes	No	Any problem with bladder or kidneys?	_____
Yes	No	Any problem with back, joints, or feet?	_____
Yes	No	Any problem with nerves, depression, etc?	_____
Yes	No	Any increase in thirst?	_____

TexomaCare Neurosurgery

Patient Name: _____ Date: _____

Medication	Dosage	Times/day

TEXOMACARE

Patient: _____ Date of Birth: _____

Consent for Treatment

The patient agrees and consents to general medical treatment by TexomaCare professionals and consents to the review and use of his/her medical records which includes the history from RXHub by any TexomaCare physician.

Understanding of Financial Responsibility

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. However, it is understood and agreed to that the patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.

Insurance Authorization and Assignment of Insurance Benefits

I hereby authorize TexomaCare to furnish information concerning my medical condition and treatment thereof to insurance carriers. I also assign insurance benefits paid on my behalf by any and all insurance companies that cover the expenses I incur as the result of any diagnostic services or treatment provided to me by any TexomaCare physician or extender. I further understand and agree that this agreement remains in force until revoked by me in writing.

HIPPA-Notice of Privacy Practices

This notice describes how medical information about the patient may be used and disclosed and how I can access to this information. Per my signature below, I acknowledge that the TexomaCare Notice of Privacy Practices has been provided to me if requested.

Signature: _____ **Date:** _____

RELEASE OF INFORMATION FOR MEDICAL RECORD OF: _____

PATIENT NAME _____

PATIENT ADDRESS _____

PATIENT DATE OF BIRTH _____

PATIENT DATE OF SERVICE _____

PATIENT TELEPHONE # _____ **PATIENT SSN** _____

√ I hereby authorize _____ to release information and forward to:
Provider

_____
_____
_____
_____

√ ***Please check type of information to be released:***

Complete Medical Record	Lab Results	X-Ray Results/Film
Notes/Results for Date of Service:	Consultation Reports	Billing Record
Immunizations	Other, *specify*	

√ ***Please check the reason the above information is released***:

Transfer to another physician	Legality Purposes	Specialist/2nd Opinion
Personal File	Disability Benefits	Other, *specify*

√ I understand that the specific information to be disclosed may include history of DRUG or ALCOHOL ABUSE, or MENTAL HEALTH TREATMENT, or information concerning communicable diseases such as HUMAN IMMUNODEFICIENCY VIRUS (HIV) and ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), and laboratory test results, treatment progress or any other such related information.

√ I understand that my treatment or payment for services will not be denied should I elect not to sign the authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. However, no protected information will be released without a signature. Also, I understand that information disclosed in accordance with this authorization may be subject to re-disclosure by the recipient and no longer protected by the Standards of Privacy of Individually Identifiable Health Information (45 CFR parts 160 & 164).

√ I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it. The authorization will expire in 180 days from the date of my signature on or otherwise specified by date, event or condition as follows:_____
_____

√ I further authorize that a photocopy of this authorization is acceptable as an original.

√ I understand I may be charged a processing fee for copies of my medical records according to Texas Hospital Licensing law.

Divorced Parents: This is to certify that I, _____, have full access to my child's medical record according to the divorce decree granted by the court.

*Patient/Parent/Guardian Name: _____

*Patient/Parent/Guardian Signature: _____

_____ _____
Signature of Patient or Legal Representative *Date*

_____
Relationship to Patient

Identity of Requestor Verified via: Photo ID Matching Signature Other, specify _____

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal & State Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500, in case of a first offense, and not more than $5,000 in the case of each subsequent offense.

Date of Request: ___/___/___ Record **copying cost: $_____.00** _____ Cash _____ Check#_____ _____ C.C.

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RELEASE OF INFORMATION FOR MEDICAL RECORDS

Form#7180-367(Rev.06/25/2008-gw)