PATIENT INFORMATION

Name:_____ [ ] Male [ ] Female
First MI Last Suffix

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Mailing Address:_____City: _____State: _____Zip: _____

Home Phone: _____Work Phone: _____Cell Phone: _____

May we leave a message? Home [ ] Yes [ ] No Cell [ ] Yes [ ] No Office [ ] Yes [ ] No

Contact Preference: [ ] Home [ ] Work [ ] Cell E-Mail: _____

Check Appropriate Box: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated [ ] Minor

Employed: [ ] Yes [ ] No Occupation: _____ Employer: _____

Person to Contact in Case of Emergency: _____

Emergency Contact Phone: _____ Relationship to Patient: _____

BILLING INFORMATION

Person Responsible for Account: _____ Date of Birth: _____/_____/_____

Relationship to Patient: _____ Phone Number: _____

Address (if different):_____

Social Security Number: _____-_____-_____ Employer: _____

RACE & ETHNICITY

What language(s) do you speak? _____ [ ] Decline

Race: _____ [ ] Decline Ethnicity: _____ [ ] Decline

NON-PHYSICIAN PRACTITIONER CONSENT

Glen Rose Healthcare, Inc. employs non-physician practitioners to assist in serving our patients. Non-physician practitioners are graduates of a certified training program and are licensed by the state board. Under the supervision of a physician, a non-physician practitioner can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care. “Supervision” does not require the constant physical presence of the supervising physician but rather overseeing the activities of and accepting responsibility for the medical services provided.

Services provided may include:

- obtaining histories and performing physical exams - developing and implementing a treatment plan
- ordering and/or performing diagnostic and therapeutic procedures - formulating a working diagnosis
- assisting at surgery - offering counseling and education - making appropriate referrals
- supplying sample medications and writing prescriptions - monitoring the effectiveness of therapeutic intervention

I have read the above and hereby consent to the services of a non-physician practitioner for my healthcare needs.

I understand that at any time I can refuse to see the non-physician practitioner and request to see a physician.

_____ _____ _____/_____/_____

Signature Printed Name Date

FINANCIAL POLICY

Please Initial:

_____ I understand that the following is expected at the time services are rendered:
- payment for visit if there is no insurance coverage
- payment for existing balance including family balances
- payment of co-insurance or co-pay
- photo ID and insurance card(s)

_____ I understand that if I fail to pay the amounts owed, Glen Rose Healthcare, Inc. has the right to secure an outside collection agency to collect unpaid debt

_____ I understand that failure to notify Glen Rose Healthcare of appointment cancellation within 24 hours of the scheduled appointment, or failure to appear for a scheduled appointment is subject to a $25 fee

_____ I understand that returned checks are subject to a $25 NSF fee

I have read and understand the financial policy of this office and agree to abide by said policy. I authorize the release of any information necessary for the purpose of evaluating and administering claims for insurance benefits. I also authorize payment of insurance benefits payable directly to Glen Rose Healthcare, Inc.

_____ _____ _____/_____/_____

Signature of Patient / Parent / Guardian | Relationship to Patient | Date

HIPAA

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. The following information must be completed by the patient annually.

Copies of your rights as a patient under HIPAA are posted for your review in the waiting area. You can also request a copy for your records at the receptionist desk. You may submit a written request to restrict the use of private information.

Information regarding my healthcare including my care, treatment or diagnosis can be released to:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

I understand that this authorization is valid until Glen Rose Healthcare, Inc. receives written notification of any changes. I acknowledge the HIPAA patient rights and privacy forms, and I have read and understand my rights.

_____ _____

Signature Patient / Parent / Guardian | Printed Name

_____ _____/_____/_____

Relationship to Patient | Date

ELECTRONIC MEDICAL RECORDS

Glen Rose Healthcare, Inc. utilizes an electronic medical records (EMR) system. We are now able to obtain medication history and send or receive prescription information electronically.

By signing below, you are granting Glen Rose Healthcare, Inc. to obtain this information on your behalf.

_____ _____ _____/_____/_____

Signature | Printed Name | Date

Authorization for Release of Medical Information

_____ _____/_____/_____ _____-_____-_____

Patient's Name Date of Birth Social Security Number

Facility Authorized to Release Health Information:

_____
Facility Name

_____
Address

_____
Phone Number

_____
Fax Number

Information to be Received by:

Glen Rose Healthcare, Inc.
Dr. Davis Dr. Vacek Dr. Patino

409 Glenwood St, Ste 500
Glen Rose, TX 76043

Phone: (254) 897-2202 or (254) 897-3369
Fax: (254) 898-1157

Health information that may be released (check all that apply):

Date from: _____/_____/_____ to _____/_____/_____ or [ ] All Dates

[ ] All Records [ ] History & Physical [ ] Lab Results [ ] Imaging Reports

[ ] Diagnostic Reports [ ] Other: _____

I specifically authorize the use or disclosure of any information in my medical record related to:

[ ] Alcohol and Drug Abuse Treatment [ ] HIV/Acquired Immune Deficiency Syndrome (AIDS)

[ ] Mental and Behavioral Health [ ] Genetic Information

Reason or Purpose for Release:

[ ] Continued Care [ ] Insurance Claim [ ] Legal [ ] Personal [ ] Disability

[ ] Other: _____

I understand the party named above is authorized by me to use or disclose my Protected Health Information for a purpose (described in this document) other than treatment, payment or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned upon me signing this authorization. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization by submitting a written request to Glen Rose Healthcare, Inc. either in person or by mail to 409 Glenwood Suite 500, Glen Rose, TX 76043.

This authorization will automatically expire 90 days after the date of signature unless otherwise specified.

By signing below, I fully understand and accept the terms of this authorization.

_____ _____/_____/_____

Signature of Patient / Parent / Guardian or Representative Date

_____

Name of Patient

_____

Relationship to Patient

SYMPTOMS

Check conditions you currently have or have had in the past year:

General

[ ] Chills
[ ] Dizziness
[ ] Fainting
[ ] Fever
[ ] Forgetfulness
[ ] Loss of sleep
[ ] Loss of weight
[ ] Nervousness
[ ] Numbness
[ ] Sweats

Gastrointestinal

[ ] Appetite poor
[ ] Bloating
[ ] Bowel changes
[ ] Diarrhea
[ ] Excessive hunger
[ ] Excessive thirst
[ ] Gas
[ ] Hemorrhoids
[ ] Indigestion
[ ] Nausea
[ ] Rectal Bleeding
[ ] Stomach pain
[ ] Vomiting
[ ] Vomiting blood

Eye, Ear, Nose & Throat

[ ] Bleeding gums
[ ] Blurred vision
[ ] Crossed eyes
[ ] Difficulty swallowing
[ ] Double vision
[ ] Earache
[ ] Ear discharge
[ ] Hay fever
[ ] Hoarseness
[ ] Nosebleeds
[ ] Persistent cough
[ ] Ringing in ears
[ ] Sinus problems
[ ] Vision – flashes
[ ] Vision – halos

Men Only

[ ] Breast lump
[ ] Erection difficulties
[ ] Lump in testicles
[ ] Penis discharge
[ ] Sore on penis
[ ] Other _____

Women Only

[ ] Abnormal pap smear
[ ] Abnormal bleeding
[ ] Breast lump
[ ] Extreme menstrual pain
[ ] Hot flashes
[ ] Nipple discharge
[ ] Painful intercourse
[ ] Vaginal discharge
[ ] Other _____
Date of last mentrual period _____
Date of last pap smear _____
Have you had a mammogram?_____
Are you pregnant?_____
Number of children_____

Muscle/Joint/Bone

Pain, weakness or numbness:
[ ] Arms [ ] Hips
[ ] Back [ ] Legs
[ ] Feet [ ] Neck
[ ] Hands [ ] Shoulders

Genito-Urinary

[ ] Blood in urine
[ ] Frequent urination
[ ] Lack of bladder control
[ ] Painful urination

Cardiovascular

[ ] Chest pain
[ ] High blood pressure
[ ] Irregular heart beat
[ ] Low blood pressure
[ ] Poor circulation
[ ] Rapid heart beat
[ ] Swelling of ankles
[ ] Varicose veins

Skin

[ ] Bruise easily
[ ] Hives
[ ] Itching
[ ] Change in moles
[ ] Rash
[ ] Scars
[ ] Sore throat that won't heal

CONDITIONS

[ ] AIDS
[ ] Alcoholism
[ ] Appendicitis
[ ] Bronchitis
[ ] Bulimia
[ ] Cataracts
[ ] Emphysema
[ ] Epilepsy
[ ] Glaucoma
[ ] Goiter
[ ] Gonorrhea
[ ] Hepatitis
[ ] Hernia
[ ] Herpes
[ ] HIV positive
[ ] Migraine
[ ] Miscarriage
[ ] Mononucleosis
[ ] Multiple Sclerosis
[ ] Mumps
[ ] Pacemaker
[ ] Pneumonia
[ ] Polio
[ ] Psychiatric care
[ ] Rheumatic fever
[ ] Scarlet fever
[ ] Suicide Attempt
[ ] Stroke
[ ] Thyroid problems
[ ] Tonsillitis
[ ] Tuberculosis
[ ] Ulcers
[ ] Vaginal infection
[ ] Venereal

MEDICAL HISTORY

[ ] Attention Deficit Disorder
[ ] ADHD
[ ] Allergies
[ ] Anemia
[ ] Anxiety
[ ] Arthritis
[ ] Asthma
[ ] Back
[ ] Bladder Disease
[ ] Blood Disorder
[ ] Cancer _____
[ ] Congestive Heart Failure
[ ] Chicken Pox
[ ] Constipation
[ ] Depression
[ ] Diabetes
[ ] Diverticulosis
[ ] Ear or Hearing loss
[ ] Edema
[ ] Eyes
[ ] GERD or reflux
[ ] Headache
[ ] Heart Disease
[ ] High Cholesterol
[ ] Kidney Disease
[ ] Kidney Stones
[ ] Liver Disease
[ ] Muscle, joint or bone
[ ] Obesity
[ ] Osteoporosis
[ ] Seizures
[ ] Stroke
[ ] Thyroid Disease
[ ] Urinary Tract Infection
[ ] Other_____

Patient Name_____ **Date of Birth:** _____

CURRENT MEDICATIONS

_____

_____

_____

_____

ALLERGIES

_____

_____

_____

_____

Pharmacy Name:_____ Phone: _____

FAMILY HISTORY

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brother(s)				
Sister(s)				

Check if your blood relatives had any of the following:		
	Disease	Relationship
	Arthritis, Gout	
	Asthma, Hay fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart disease, strokes	
	High blood pressure	
	Kidney disease	
	Tuberculosis	
	Other	

HOSPITALIZATIONS / SURGICAL HISTORY

Year	Hospital	Reason for hospitalization
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had a blood transfusion? [ ] Yes [ ] No

If yes, approximate dates? _____

PREGNANCIES

Year of Birth	Sex	Complications
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

Other Serious Illnesses: _____

_____

_____

SOCIAL HISTORY

Smoking Status _____

Years of Use _____

Deaf or serious difficulty hearing? [ ] Yes [ ] No

Blind or serious difficulty seeing? [ ] Yes [ ] No

Difficulty concentrating, remembering or making Decisions? [ ] Yes [ ] No

Difficulty walking or climbing stairs? [ ] Yes [ ] No

Difficulty Dressing or bathing? [ ] Yes [ ] No

Difficulty doing errands alone? [ ] Yes [ ] No

Occupation _____

Marital Status _____

Alcohol Intake _____

Caffeine Intake _____

Chewing Tobacco use _____

Advance Directive [ ] Yes [ ] No

Illicit Drugs _____

Do not resuscitate on file [ ] Yes [ ] No

Patient Name_____ **Date of Birth:** _____