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: ______________________________

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

Relationship to Patient: __________________________________ Phone Number: ____________________________

Address (if different):____

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

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

Race: ___________________________ [ ] Decline Ethnicity: ____________________________ [ ] Decline

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

BILLING INFORMATION

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

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

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

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

_______________________________________ _____/_____/________ _______-_____-_______

Patient's Name | Date of Birth | Social Security Number

Authorization for Release of Medical Information

Facility Authorized to Release Health Information:

____

Facility Name

____

Address

____

Phone Number

____

Fax Number

Information to be Received by:

Glen Rose Healthcare, Inc.
Dr. Michael Davis or Dr. Albert Jay Turk

PO Box 3129
Glen Rose, TX 76043

Phone: (254) 897-2202

Fax: (254) 897-2102

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 PO Box 3129, 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.

ELECTRONIC MEDICAL RECORDS

_______________________________________ _____/_____/_____

Signature of Patient / Parent / Guardian or Representative | Date

____

Name of Patient

____

Relationship to Patient

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

SYMPTOMS

General

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

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

Gastrointestinal

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

Cardiovascular

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

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

Skin

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

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______

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

[ ] Attention Deficit Disorder
[ ] Blood Disorder
[ ] Edema
[ ] Muscle, joint or bone

[ ] ADHD	[ ] Cancer ______________	[ ] Eyes	[ ] Obesity
[ ] Allergies	[ ] Congestive Heart Failure	[ ] GERD or reflux	[ ] Osteoporosis
[ ] Anemia	[ ] Chicken Pox	[ ] Headache	[ ] Seizures
[ ] Anxiety	[ ] Constipation	[ ] Heart Disease	[ ] Stroke
[ ] Arthritis	[ ] Depression	[ ] High Cholesterol	[ ] Thyroid Disease
[ ] Asthma	[ ] Diabetes	[ ] Kidney Disease	[ ] Urinary Tract Infection
[ ] Back	[ ] Diverticulosis	[ ] Kidney Stones	[ ] Other___________________
[ ] Bladder Disease	[ ] Ear or Hearing loss	[ ] Liver Disease	___________________________

Patient Name____ **Date of Birth:** _________________________

CURRENT MEDICATIONS

____

____

____

ALLERGIES

____

____

____

Pharmacy Name:____ Phone: ______________________________

FAMILY HISTORY

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

HOSPITALIZATIONS / SURGICAL HISTORY

Year Hospital Reason for hospitalization

_______ ____________________ ____

_______ ____________________ ____

_______ ____________________ ____

_______ ____________________ ____

_______ ____________________ ______________________________

PREGNANCIES

Year of Birth Sex Complications

_____ ______________________

_____ ______________________

_____ ______________________

_____ ______________________

Other Serious Illnesses: ______________________

____

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

If yes, approximate dates? ____

SOCIAL HISTORY

Smoking Status ____________________________

Years of Use ______________________________

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

Occupation ________________________________

Marital Status _____________________________

Alcohol Intake _____________________________

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

Caffeine Intake ___________________________

Chewing Tobacco use ______________________

Advance Directive [ ] Yes [ ] No

Illicit Drugs _______________________________

Do not resuscitate on file [ ] Yes [ ] No

Patient Name____ **Date of Birth:** ___________________________