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Patient Registration - Consent for Treatment

Patient Information

Patient's Last Name: _____ First Name: _____ Middle Initial: _____
Social Security Number: _____ Marital Status: _____
Gender: Male Female Age: _____ Date of Birth: _____
Home Phone: _____ Cell Phone: _____
Mailing Address: _____
Residential Address (if different): _____
City: _____ State: _____ Zip Code: _____
Email Address: _____
Race/Ethnicity: _____ Preferred Language: _____

Insurance Information - Please give your Insurance Card(s) to the receptionist

Primary Insurance: _____
Policy Holder/Subscriber Name: _____
Date of Birth: _____ Gender: Male Female
Patient's Relationship to Policy Holder/Subscriber: _____
Secondary Insurance: _____
Policy Holder/Subscriber Name: _____
Date of Birth: _____ Gender: Male Female
Patient's Relationship to Policy Holder/Subscriber: _____

Emergency Contact Information

Name: _____
Relationship: _____ Contact Number: _____

Provider or Referring Doctor Information

Referring Doctor Name/Number: _____
How did you hear about us? Google Ad Google Search Social Media
 Family/Friend Other Provider Insurance Provider

I authorize the release of my medical information necessary to process this claim for payment of insurance benefits to **DFW Family Clinic**. I understand I am responsible for all charges insurance does not pay including non-covered procedures. I also understand if the insurance information I provided is not correct this could result in my claims not being processed by the correct insurance carrier and I will be responsible for all charges. I consent to treatment as deemed necessary by providers and employees.

Patient Signature: _____ Date: _____

Pharmacy of Choice

Name: _____

Address: _____ Phone Number: _____

Patient History Form

This is a confidential record.

Information contained here will not be released to anyone without your authorization to do so.

Today's Date: _____ Date of Last Exam: _____

Last Name: _____ First Name: _____ Date of Birth: _____

Current Prescription Medicines:	<input type="checkbox"/> None	Please show your medication bottles to the nurse.	
Name of Drug	Dose	Quantity (# tablets)	Frequency (#times/day)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

Past Medical, Family & Social History

List any personal past illness and/or surgeries and when they occurred.

Illness or Surgery	Date
_____	_____
_____	_____
_____	_____

- Tobacco Use? Never Occasionally Daily
- Type of Tobacco Used: Snuff Dip Cigarettes Cigar Pipe E-cigarette
- Alcohol Use? Never Occasionally Daily Beer Wine Liquor
- Illegal Drug Use? Never Occasionally Daily

List all chronic health illnesses in your immediate family (ex: diabetes, tuberculosis, breast cancer, heart disease, etc.)	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Last Mammogram/Results: _____ Last Pap/Results: _____

Last Bone Density/Results: _____ Last EKG/Results: _____

Last PSA/Prostate Exam: _____ Last Stress Test/Results: _____

Last Colonoscopy/Results: _____ Last Eye Exam: _____

Last Dental Exam: _____

- Are you on a special diet? Yes No If yes, please explain: _____
- Do you exercise regularly? No Daily Weekly Other: _____
- Do you have allergies? Yes No If yes, please explain: _____

Advanced Directive? Yes No (Living Will)
Hepatitis A, B, C _____ Risks
Exposure to Hepatitis: Yes No
Tattoos? Yes No
Blood Transfusion prior to 1992? Yes No

Immunizations (date)

Flu: _____

Pneumonia: _____

Diphtheria/Tetanus: _____

Shingles: _____

COVID: _____

Other: _____

Provider: _____ Date: _____

HIPAA Privacy Act Information and Consent

Please check one of the boxes below for release of medical information:

Release information **only to me**: Yes No

Release information to additional persons: Yes No

Please answer the following questions:

May we communicate with you via phone call? Yes No

May we communicate with you via email? Yes No

May we leave a message/voicemail when we make a phone call to you? Yes No

May we discuss your medical condition with anyone other than you, the patient? Yes No

May we communicate via SMS? Yes No

If yes, please list the name(s) of the individual(s) that you authorize to receive medical information:

The following persons may receive consultation concerning specific medical information:

Name: _____

Relationship: _____ Contact Number: _____

Release specified information (state ALL or SPECIFY): _____

Name: _____

Relationship: _____ Contact Number: _____

Release specified information (state ALL or SPECIFY): _____

**Additional names should be recorded on additional form.*

Patient Signature Printed Name Date

Acknowledgement of Receipt of Notice of Privacy Practices

DFW Family Clinic reserves the right to modify the privacy practices outlines in the notice. I have received a copy of the Notice of Privacy Practices.

Patient Signature Printed Name Date

Printed Name of Legal Guardian (if applicable) Date

Relationship to Patient: _____
Required if the patient is a minor or an adult who is unable to sign the form.