DFW Family Clinic

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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 ☐ Insurance Provider ☐ Other 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: _____

Pharmacy of Choice

Name: _____

Address: _____

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: ☐ 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	☐ Cigar	☐ Pipe	☐ E-cigarette
Alcohol Use?	☐ Never	☐ Occasionally	☐ Beer	☐ Wine	☐ Liquor
Illegal Drug Use?	☐ Never	☐ Occasionally	☐ Daily		

List all chronic health illness 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? _____

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 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.