FAMILY HEALTH PRO CLINIC - Senior Living Facility Registration Information

1888 Graham Drive, Tomball, TX 77375 Phone: 281-255-2001 Fax: 281-516-7751

*form updated 2018 April

Patient Name: _____Male: ____ Female: ____

Home Address: _____

City: _____ State: _____ Zip Code: _____

S.S. #: _____Birth Date: _____Main Phone: _____

E-mail Address: _____ Marital Status: _____

Emergency Contact Name _____ Relation: _____Phone: _____

Ethnicity: Caucasian Hispanic African-American Other: _____

Insurance Information

Primary Insurance Policy

Insurance Name: _____ Name of Insured: _____

Is the insured a patient? Yes Or No Insured's Date of Birth: _____

Patient's relation to the insured: __ Self __ Spouse __ Child __ other _____

Insured's ID #: _____ Group #: _____

Secondary Insurance

Insurance Name: _____ Name of Insured: _____

Is the insured a patient? Yes Or No Insured's Date of Birth: _____

Patient's relation to the insured: __ Self __ Spouse __ Child __ other _____

Insured's ID #: _____ Group #: _____

Policy Holder / Responsible Party Information

Name: _____ Male: __ Female: __

Relationship to Patient: _____

Address: _____

S.S. #: _____ Birth Date: _____

Home Phone:_____ Cell Phone: _____ Work:_____

Please be aware that we collect estimated insurance portions at each visit. Your insurance policy is a contract between you and your insurance company. You are responsible for any unpaid balances, regardless of the original estimate of the insurance benefit. As a courtesy to you we will file your claims with your insurance company. Insurance payments are usually received within 30-45 days. **Any unpaid balances after 60 days are your responsibility and are due at that time. All deductibles and co-payments are due at the time of service.** A copy of your insurance card will need to be kept on file in our office. We try to answer any questions you may have about your insurance company, however you may need to contact your insurance company for additional information. If your insurance changes, it is your responsibility to provide updated information to our office. To assist with issues in between scheduled visits as well as after hours, patients may be managed concurrently with Nurse Practitioner who works for separate corporation. Unless stated otherwise, records will be shared with them, and related visits will be billed by their corporation.

Assignment of Benefit

Please read and sign to have our office file your insurance: I authorize the release of information and understand that I am responsible for all costs of medical treatment. I hereby authorize payment directly to George Valdez, MD of the insurance benefits otherwise payable to me.

Patient Signature: _____Date: _____

Guardian Signature:_____Date: _____

Patient HIPAA Acknowledgment and Consent Form

_____ **(Patient initials)** Notice of Privacy Practices. I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ **(Patient initials)** Release of Information. I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations.

Disclosures to Friends and/or Family Members: I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name, Relationship, Contact Number

1: _____

2: _____

Patient Signature: _____Date: _____

Guardian Signature:_____Date: _____

BRIEF MEDICAL HISTORY QUESTIONNAIRE

Describe briefly current active concerns:

Hospitalizations in last year (include where, when, & for what reason):

Please list the names of other providers currently seeing, type of specialty, and issues they are addressing:

When was last **vision** exam/Name of Specialist:

When was last **dental** exam/Name of Specialist:

When was last **foot** exam/Name of Specialist:

When was last **skin** exam/Name of Specialist:

If insurance is regular Medicare, patient can still see prior primary care and we can coordinate with them.

BASIC DIRECTIVES: Hopefully not anytime soon, but if illness suddenly happens or gets worse, would the patient:
(1) prefer to not go to the hospital, no matter what (treat conservatively with meds only, if not responding then pass away at home with comfort meds),
(2) go to the hospital to diagnose and stabilize but use medications only, comfort care only if continues to worsen.
(3) go to hospital, treatment to include ventilator/artificial breathing up to 2 weeks if needed, but *no aggressive CPR*.
(4) go to hospital with treatment to include ventilator for prolonged period if needed, but *no aggressive CPR*. or
(5) go to hospital with treatment to include ventilator and *aggressive CPR*
Preference can always be changed, but it is helpful to have basic understanding before emergency arises.

**Aggressive CPR* usually includes chest compressions/breaking ribs, shocking heart with electricity, medications to artificially support blood pressure, with around 15% short term survival rate after 80 year old

CURRENT MEDICATIONS - DISREGARD IF ALREADY FILLED OUT ELSEWHERE

Drug allergies: ❑ No ❑ Yes To what?

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	Dose (strength & number of pills per day)	Reason for taking?	Concerns?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

PAST MEDICAL HISTORY

Does the patient now or has ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Skin Breakdowns
- ❑ Cancer (type) _____
- ❑ Seizures
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):

_____

_____

In the past month, has the patient had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Double or blurred vision
- ❑ Dryness

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Anxiety
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Mood swings
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts

OTHER PROBLEMS:

FAMILY HEALTH PRO CLINIC
888 Graham Drive, Suite 100
Tomball, TX 77375

Phone: 281-255-2001
Fax: 281-516-7751
www.familyhealth.pro

Navigating Health Care with Quality, Efficiency, Compassion

Authorization To Obtain/Release Medical Information

You must complete this form thoroughly.

Patient's Name: _____ Date Of Birth: _____

Address: _____

I hereby authorize Family Health Pro Clinic to obtain or share my health information.

To assist with issues in between scheduled visits as well as after hours, patients may be managed concurrently with Nurse Practitioner who works for separate corporation.

Unless stated otherwise, records will be shared with them. Please send records within 14 business days.

Name of *Prior* Physicians or Medical Facility: _____

Address: _____Phone: _____ Fax: _____

Information to be released: _____

Current Other Treating Physicians we may send/receive health information with:

Name:_____Specialty:_____

Address: _____Phone: _____ Fax: _____

Name:_____Specialty:_____

Address: _____Phone: _____ Fax: _____

Others:_____

Conditions Of Authorization

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain records. I may revoke this authorization by writing a letter and mailing it certified, return receipt requested, to the Privacy Officer at the health provider listed above. Information used or disclosed pursuant to the authorization may be subject to re-discloser by the recipient and longer protected by Federal Privacy Regulations.

This authorization is valid for the release of information as indicated above. Only records form this facility can be legally released. Any record for other physicians must be obtained from them.

Signature: _____Date:_____

Parent/ Guardian Signature:_____Date:_____