PATIENT INFORMATION/CONSENT FORM

CONROE FAMILY DOCTOR

NAME: _____, _____, _____ DATE OF BIRTH: _____
LAST *FIRST* *MIDDLE* *AGE:* _____
ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

EMAIL: _____

GENDER: **MALE OR FEMALE** MARITAL STATUS: **MARRIED** OR **SINGLE** OR **DIVORCED** OR **WIDOW/ER** CHILDREN: _____

ETHNICITY: (Please Circle) **AMERICAN INDIAN / ALASKA NATIVE, ASIAN, NATIVE HAWIIAN OR OTHER PACIFIC ISLANDER BLACK OR AFRICAN AMERICAN / WHITE / HISPANIC / OTHER RACE / REFUSE TO REPORT**

PATIENT'S SS#: _____ PATIENT'S DRIVER'S LICENSE _____

INSURED NAME: _____ INSURED'S SS#: _____ INSURED DATE OF BIRTH: _____
(IF DIFFERENT FROM PATIENT) Address: _____

EMPLOYER'S INFORMATION

COMPANY'S NAME: _____ COMPANY'SADDRESS: _____ COMPANY'SPHONE: _____

HEALTH INFORMATION

PREFERRED PHARMACY: _____ PHARMACY'S PHONE: _____

ALLERGIES: _____

MEDICINES: PLEASE LIST YOUR MEDICINES AND DOSAGES ☐ **PLEASE CHECK IF YOU TAKE NO MEDICINES**

1.	**4.**	**7.**	**10.**	**13.**
2.	**5.**	**8.**	**11.**	**14.**
3.	**6.**	**9.**	**12.**	**15.**

MEDICAL HISTORY: PLEASE CIRCLE YOUR MEDICAL PROBLEMS ☐ **PLEASE CHECK IF YOU HAVE NO MEDICAL PROBLEMS**

ASTHMA	HEART DISEASE	HEART ATTACK	THYROID DISEASE	SEIZURES	CANCER: WHAT TYPE?
DIABETES	HIGH BLOOD PRESSURE	GLAUCOMA	ANXIETY/DEPRESSION	KIDNEY DISEASE	
EMPHYSEMA/COPD	IRREG HEARTBEAT/AFIB	ARTHRITIS/JOINT DISEASE	STROKES	LIVER DISEASE	

PLEASE LIST OTHER MEDICAL PROBLEMS NOT LISTED: _____
FEMALE: NUMBER OF PREGNANCIES _____ NUMBER OF CHILDREN _____ NUMBER OF PREGNANCY LOSS _____

PAST SURGERIES: PLEASE CIRCLE PAST SURGERIES ☐ **PLEASE CHECK IF NO PAST SURGERIES**

APPENDIX	GALLBLADDER REMOVAL	CARPAL TUNNEL	LOW BACK SURGERY	NECK SURGERY	PROSTATE SURGERIES
HYSTERECTOMY W OVARIES REMOVED	C-SECTION: HOW MANY?_____	OPEN HEART SURGERY/ BYPASS	JOINT REPLACEMENT: SHOULDER: RIGHT/LEFT KNEE : RIGHT/LEFT HIP: RIGHT/LEFT		TONSILLECTOMY
HYSTERECTOMY ONLY	CATARACT- RIGHT/LEFT	MASTECTOMY/LUMPECTOMY RIGHT/LEFT	ARTHROSCOPIC SURGERY: KNEE: RIGHT/LEFT SHOULDER: RIGHT/LEFT		HEART STENTS/ ANGIOPLASTY

PLEASE LIST OTHER SURGERIES NOT LISTED: _____

DO YOU USE TOBACCO? ☐ YES ☐ NO HOW MUCH? _____ WHEN DID YOU START? _____

CIRCLE WHICH TOBACCO PRODUCT: CIGARETTES/CIGARS/SMOKELESS

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO HOW MUCH? _____ HOW OFTEN? _____

PREVENTIVE CARE:

COLONOSCOPY:	DATE	MAMMOGRAM:	DATE	FLU VACCINE:	DATE
PAP SMEAR:	DATE	PSA:	DATE	PNEUMONIA VACCINE:	DATE
BONE DENSITY:	DATE	CHOLESTEROL:	DATE	ZOSTAVAX/SHINGLE VACCINE:	DATE

FAMILY HISTORY: PLEASE CIRCLE YOUR FAMILY MEDICAL PROBLEMS ☐ PLEASE CHECK IF YOU WERE ADOPTED

ASTHMA	SEIZURES	KIDNEY DISEASE	LIVER DISEASE	DEPRESSION	GALLBLADDER DISEASE
HIGH BLOOD PRESSURE	HEART DISEASE/HEAR ATTACK	HIGH CHOLESTEROL	BLOOD DISORDER	CANCER? PLEASE LIST	
STROKES	DIABETES	THYROID DISEASE	ALCOHOLISM		

PLEASE LIST OTHER FAMILY MEDICAL PROBLEMS NOT LISTED: _____

IN CASE OF EMERGENCY CONTACT: _____ PH: _____ RELATIONSHIP: _____

INSURANCE AUTHORIZATION/ASSIGNMENT AND CONSENT FOR TREATMENT (PLEASE READ AND SIGN)

I hereby authorize Conroe Family Doctor, PLLC to furnish information to all legitimately involved parties concerning my illness and treatments and that I hereby assign to Conroe Family Doctor, PLLC all payments for medical services rendered to me or to my dependents. I understand that I am responsible for all charges. I consent to and authorize Conroe Family Doctor, PLLC to treat.

I also understand and agree that I am ultimately financially responsible for services provided to myself and my dependents. These services are to include changes that are either denied or not covered by my insurance policy, co-pays, and co-insurances as designated by my insurance policy. A deposit of $150 will be required for all services provided without insurance coverage. I also understand that I may receive additional billing from outside vendors, e.g. radiology, pathology, laboratory, durable medical equipment, etc.

SIGNATURE: _____ DATE: _____

GUARDIAN SIGNATURE: _____ DATE: _____

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO DESIGNATED REPRESENTATIVE(S)

I, _____, give my authorization to release my protected health information including results of my laboratory tests, x-ray and/or other test results to the following designated representative(s):

Patient Initials

_____ My spouse (Name) _____

_____ My child (Name) _____

_____ Other (Name) _____

_____ Personal Representative _____

_____ May be left on my answering machine at home.

_____ May be left on my answering machine at work.

_____ May be left on my cell phone. _____

_____ MAY NOT BE GIVEN TO ANYONE OTHER THAN MYSELF.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Relationship: _____ Date: _____

Witness Signature: _____ Date: _____

As a patient, you have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. For the revocation of this authorization to be effective, Conroe Family Doctor, PLLC must receive the revocation in writing. The revocation must include, 1) the patient's name, address, and date of birth, 2) the patient's desire to revoke the authorization, and 3) the date of the revocation and the patient's signature. All revocations must be sent in writing to the attention of Conroe Family Doctor, PLLC Privacy Officer at 1020 Riverwood Ct., Suite 100, Conroe, TX 77304 or faxed to (936) 494-4012 and will not be considered effective until received by the Privacy Officer.