

Baylor Family Medicine

3701 Kirby, Suite 100, Houston, TX 77098 t713-798-7700 f713-798-7775

Patient Registration

Date: _____

<input type="checkbox"/> Check here if you submitted your health information through MyChart.

Patient Information:

DR. LIC. #: _____ SOC. SEC. #: _____ Referred by: _____

Patient Name: _____ M F Date of Birth: _____
(Last) (First) (Middle) (Circle One)

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____ Home Phone: (____) _____

E-mail address: _____ Cell Phone: (____) _____

Employer: _____ Occupation: _____

Address: _____ Bus. Phone: (____) _____

City: _____ State: _____ Zip: _____

Parent/Guardian Information

Parent Guardian Name: _____ Relationship to Patient: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____

(If patient is over 18, parent / guardian must have the patient sign a medical records release to obtain clinical information)

EMERGENCY CONTACT: _____ Relationship to Patient: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____

Insurance Information:

Policy Holder's Name: _____

Policy Holder's Social Security Number: _____ Policy Holder's Date of Birth: _____

• • • NO SHOW POLICY • • •

Baylor Family Medicine requires patients to call and cancel a scheduled appointment AS SOON AS POSSIBLE. We prefer to hear from you NO LATER THAN 1 hour prior to the appointment if you need to cancel and reschedule. A letter will be sent to patients who do not show up for their scheduled appointment. Several no-showed appointments will result in patients being terminated from the Baylor Family Medicine clinical practice.

PAYMENT IN FULL IS REQUIRED AT THE TIME OF YOUR VISIT

Health History Questionnaire

Last Name _____ First Name _____ M.I. _____ Today's Date _____

Birthplace _____ Education Level _____ Occupation _____

Single _____ Married _____ Committed relationship _____ Separated _____ Divorced _____ Widowed _____

Who lives at home with you? _____

MEDICAL HISTORY Please check conditions you have now, or have had in the past. Or list below.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Anxiety/depression |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Alcohol/drug Abuse |

HOSPITALIZATIONS List all times in the hospital, for illness or surgery, beginning with the most recent.

<u>Date</u>	<u>Reason</u>	<u>Hospital</u>	<u>Physician</u>

MEDICATIONS, VITAMINS, SUPPLEMENTS

Our staff will enter your prescription medications into our electronic medical record, so please have that information ready. Circle the following non-prescription medications that you use:

- | | | | |
|---------------|---------------------|--------------|-----------------------|
| Laxatives | Antacids | Aspirin | Ibuprofen or Naproxen |
| Decongestants | Allergy Pills | Nasal Sprays | Natural Hormones |
| Vitamins | Herbs (Please list) | Supplements | Other _____ |

ALLERGIES If you are allergic to any of the following, please describe the reaction you had.

Penicillin _____ Sulfa _____ Other _____

LIFESTYLES AFFECTING HEALTH Please answer these questions.

- Weight: Now _____ 1 year ago _____ Desired _____
- Habits: Use seat belts 80-100% _____ 50-80% _____ Less than 50% _____
- Tobacco: Never _____ Age started _____ Age stopped _____
- Cigarettes _____ (packs/day) Cigars _____ Pipe _____ Snuff _____ Chewing tobacco _____
- Alcohol: Never _____ 0-6 drinks/week _____ 7-14 drinks/week _____ Over 14/week _____
- Caffeine: Drinks per day _____ Special diet? Type: _____
- Exercise: Type: _____ Frequency, distance or amount: _____
- Women: Do you do regular breast self-exam? Yes No
- Men: Do you do regular testicular self-exam? Yes No

Patient Name: _____

Please Complete Back Of Page ►

FAMILY HISTORY

Family History	If Living		If Deceased		Disease	√	Relationship of relative
	Age	Health	Age at Death	Cause			
Father					Allergies		
					Asthma		
					Arthritis		
Mother					Glaucoma		
					Cancer-What kind?		
1. Brother/Sister <i>(circle one)</i>					Tuberculosis		
2. Brother/Sister					Diabetes		
					Heart Trouble		
3. Brother/Sister					High Blood Pressure		
					Stroke		
4. Brother/Sister					High cholesterol		
					Stomach ulcers		
Spouse					Epilepsy/Seizures		
					Substance Abuse		
1. Son/Daughter <i>(circle one)</i>					Anxiety		
					Depression		
2. Son/Daughter					Suicide		
					Kidney Trouble		
3. Son/Daughter					Birth Defects		
					Sickle Cell Anemia		
4. Son/Daughter					Mental Retardation		

PREVENTIVE SERVICES List the date you last had these preventive medicine services or tests.

Physical examination: _____ Physician: _____

Heart Disease Prevention:

High cholesterol: Lipid profile _____

Cancer Screening:

Breast cancer: Mammogram _____

Cervical cancer: PAP smear _____

Colon cancer: Colonoscopy _____ OR stool test _____ plus flexible sigmoidoscopy _____

Prostate cancer: PSA (prostate specific antigen) _____

Infectious Disease Prevention: (List year of most recent immunization)

MMR _____

Tetanus _____

Hepatitis B _____

Flu _____

Pneumonia _____

Hepatitis A _____

Osteoporosis Screening:

DEXA Scan (bone density test) _____

MENSTRUAL HISTORY

Age at onset _____

Cycle (from start to start) _____ days

Date of last period _____

If post-menopausal, age at last period _____

Usual duration of flow _____ days

Flow is: Heavy ___ Medium ___ Light ___ Pain or cramp? _____

Periods irregular? _____

Have had vaginal infections or frequent discharge? _____

Taking birth control pills? _____

Have an IUD? _____ Have had abnormal PAP? _____

Pregnancies Total number _____

Number of children born alive? _____

Please Complete Back Of Page ►

Name: _____

Date: _____

CURRENT SYMPTOMS:

Please circle those symptoms you are currently experiencing within the last **TWO WEEKS**.

Please understand that all concerns may not be addressed due to limitations of your provider's schedule.

General:

loss of appetite
chills
fatigue
fevers
feeling lousy
sleep disorder
sweats
weight loss

Eyes:

blurred vision
color blindness
contacts/glasses
double vision
discharge
eye pain
irritation
yellow eyes
light sensitivity
redness
visual disturbance
vision loss

Ear/Nose/Throat:

ear drainage
earaches
nose bleeds
facial trauma
hearing loss
hoarseness
nasal congestion
snoring
sore mouth
sore throat
ear ringing
voice change

Cardiovascular:

chest pain
chest pressure
calf pain with walking
difficulty breathing
chest discomfort with exertion
fatigue
irregular heart beats
swelling
lightheadedness
short breath with laying
palpitations
fainting

Respiratory:

cough
short breath at rest
short breath with exertion
coughing blood
pleurisy
sputum
wheezing

Gastrointestinal:

difficulty swallowing
painful swallowing
indigestion
reflux symptoms
nausea
vomiting
change in bowel habits
black tarry stool
diarrhea
constipation
abdominal pain
jaundice
gas/bloating

Genito-urinary:

decreased stream
painful urination
frequency
blood in urine
hesitancy
urinating at night
urinary incontinence
abnormal menstrual periods
genital lesions
hot flashes
pelvic pain
sexual problems
vaginal discharge
erectile dysfunction
genital lesions
penile discharge
sexual problems

Skin/Breast:

breast lump
breast tenderness
changed mole
dryness
hair changes
nipple discharge
itchy skin
rash
skin color change
skin lesion(s)

Musculoskeletal:

joint pains
back pain
bone pain
joint swelling
leg pain at night
leg pain with exertion
muscle cramps
muscle weakness
neck pain
stiff joints

Neurology:

coordination problems
difficulty walking
dizziness
frequent falls
gait problems
headaches
memory problems
numbness
seizures
speech problems
transient blindness
tremor
vertigo
weakness

Psychiatric:

abusive relationship
aggressive behavior
loss of appetite
anxiety
behavior problems
confusion
depression
excessive alcohol consumption
hallucinations
illegal drug usage
learning difficulty
mood swings
paranoia
repetitive activity
school difficulties
school phobia
separation anxiety
sexual difficulty
sleep disturbance
suicidal thoughts

Endocrine:

urinating a lot
drinking a lot
poor wound healing
eating a lot
itchy skin
skin dryness
weight
fertility problems
temperature intolerance

Blood/Lymph:

bleeding
easy bruising
swollen lymph nodes

Allergic:

anaphylaxis
hay fever
hives

Baylor Family Medicine Financial Policy

To our patients:

Thank you for selecting our office for your medical care. In order to prevent any misunderstanding concerning the responsibility for payment for medical services provided to our patients, the following information is supplied:

The patient or their guarantor is responsible for payment for services provided by **BAYLOR FAMILY MEDICINE** at the time of service. The only exception is if BAYLOR FAMILY MEDICINE has contracted with your HMO/PPO/POS, Medicaid, or Medicare to accept the insurance payment as payment in full after all deductibles have been met and all co-pays has been paid.

We will furnish you with a copy of your bill at each visit, which contains all the information necessary for you to bill your insurance carrier. Charges for an office visit range from \$30 to \$200 +. Additional services such as laboratory and radiology are an additional charge and you will be billed separately.

HMO/PPO/POS or other Contracted Insurance Coverage:

If you have insurance coverage through a company that we have contracted with, we require a copy of your insurance card. Failure to provide this will result in your paying the full amount of the visit at the time of service. Payment of your deductible, co-payment and/or non-covered service is expected at the time of service.

MEDICAID:

If you have Medicaid coverage, we must make a copy of your Medicaid card at each visit. If you have pending Medicaid coverage, we require payment for the services at the time of your visit. If, within three months after your visit, you provide a retroactive Medicaid card that covers that date of service, we will refund your payment after Medicaid reimburses us for your visit.

MEDICARE:

Our physicians are participating Medicare providers. Office visits to a doctor are covered under part B of the Medicare program. Medicare pays 80% of their **allowable** charges after **you pay your annual deductible** for the calendar year. If you have supplemental insurance we require a copy of your insurance card.

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS

In the event that my insurance company denies payment for services rendered, I accept responsibility for the payment due depending on my insurance company's contract with Baylor Family Medicine.

In the event that I am not covered by insurance, I understand that I am responsible for payment in full.

I hereby authorize Baylor Family Medicine to release any information acquired in the course of my examination or treatment that may be necessary to process my claim. In consideration of services rendered, I hereby authorize payment, not to exceed reasonable and customary charges, directly to Baylor Family Medicine (TXN# 74-1613878).

Patient Signature: _____

Date: _____

Responsible Party: _____

Date: _____

Patients Name: _____