Total Health and Wellness

New Patient Registration Form

Last Name: _____ First Name: _____ Middle Initial: _____

Other last names you have used: _____

Date of Birth: _____ Age: _____ Social Security #: ___ — ___ — ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/er Driver's License: _____

Sex: ☐ Female ☐ Male Race/Ethnicity: _____

Address : _____ Mail Address: (If Different) Same ☐ _____

City, State: _____ Zip Code: _____ City, State: _____ Zip Code _____

Primary Phone: _____ Other Phone: _____

Personal Email: _____ Other Email: _____

Emergency Contact

Name: _____ Primary Phone: _____

Relationship : _____ Other Phone: _____

Pharmacy

Name: _____ Phone #: _____

Address : _____ _____

City, State: _____ Zip Code: _____ Fax #: _____

Past Medical History

Previous Physician's name:_____ Date of last exam:_____

Have you ever been hospitalized?_____ If yes, what for?_____

Have you ever been tested for hepatitis A, B or C? ☐ Yes ☐ No Which hepatitis virus?_____

Have you been vaccinated for hepatitis A,B or C ? ☐ Yes ☐ No If yes, date vaccine series was completed_____

Last Tuberculosis (TB) screening_____ Result of TB screening ☐ Positive ☐ Negative

If positive TB screen, date of last chest x-ray_____ Result of Chest X-ray ☐ Positive ☐ Negative

Have you had a sexually transmitted disease? ☐ Yes ☐ No Diagnosis_____

Which of the following conditions are you currently being treated or have been treated for in the past (Please Check)

☐ Heart disease/Murmur/Angina	☐ Shortness of breath	☐ Eye disorder/Glaucoma	☐ Diabetes
☐ High Cholesterol	☐ Asthma/ COPD	☐ Seizures	☐ Kidney/ Bladder problems
☐ High blood pressure	☐ Tonsillitis	☐ Stroke	☐ Liver problems/ Hepatitis
☐ Low blood pressure	☐ Sinus problems	☐ Headaches/ Migraines	☐ Arthritis
☐ Blood disorders/ Anemia	☐ Seasonal Allergies	☐ Neurological problems	☐ Cancer/ Immunological disorders
☐ Swollen Ankles	☐ Ear problems	☐ Psychiatric care	☐ Thyroid Problems
☐ Heartburn (reflux)/ GERD	☐ Depression/ Anxiety	☐ Cough	☐ Ulcers/ Colitis

Please list past surgeries and procedures

_____

_____

Allergies

Do you have any food or drug allergies? ◻ Yes ◻ No Please list _____

Medications (Please include all your prescription **medications, herbs, vitamins, supplements and aspirin**)

NAME	STRENGTH	FREQUENCY

Social and Preventive History

Do you currently smoke or chew tobacco? □Yes □No if no, have you in the past? □Yes □No How many packs per day? _____

Do you drink alcohol, beer, or wine? □Yes □No if no, have you in the past? □Yes □No How many drinks per week? _____

Do you currently drink coffee and/or tea? □Yes □No if yes, how many cups per day? _____

Do you exercise daily/weekly? □Yes □No

Do you use seatbelts while driving? □Yes □No

Do you wear a helmet while riding a bike? □Yes □No

Family History Living Age (or age at death) List serious illnesses

Mother □Yes □No _____ _____

Father □Yes □No _____ _____

Siblings □Yes □No _____ _____

□Yes □No _____ _____

□Yes □No _____ _____

Females: Gynecological History

How many times have you been pregnant? _____ Date of last Pap smear: _____

Have you had an abnormal Pap smear? □Yes □No Diagnosis: _____ Follow up: _____

Have you had a sexually transmitted disease? □Yes □No Diagnosis: _____

Date of last mammogram: _____ Results: □ Normal □ Abnormal / Were you biopsied? □Yes □No Results: _____

Additional Screenings

Colonoscopy screening? □Yes □No Date: _____ Diagnosis: _____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate. Patient/Legal Guardian Signature _____ Date _____

Total Health and Wellness

RELEASE OF MEDICAL RECORDS CONSENT FORM

The patient/guardian/parent signed and dated below agrees to have the following records released to Total Health and Wellness for the purposes of medical treatment.

Patients Name_____

Date of Birth_____

SSN_____

____ All Records

____ Specific Records (please list below)

_____

_____

Name of Previous Doctor(s) or Clinic(s)_____

Phone_____Fax_____

Name of Previous Doctor(s) or Clinic(s)_____

Phone_____Fax_____

Name of Previous Doctor(s) or Clinic(s)_____

Phone_____Fax_____

Medical records can be faxed or mailed to:

Total Health and Wellness

___ Sherry Hoover, RNC-FNP

6435 S. FM 549
Suite 203A
Heath, TX. 75032
Phone: 972-722-5552
Fax: 972-722-6655

PATIENT'S SIGNATURE_____

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

Total Health and Wellness

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Total Health and Wellness or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due.

MEDICARE/MEDICAID INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Total Health and Wellness or the physician on my behalf.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

ACKNOWLEDGEMENT OF POTENTIAL FINANCIAL INTEREST IN ANCILLARY SERVICES

I acknowledge that my treating physician may have a financial interest in the overall performance of ancillary services as part of his/her affiliation with a group practice. I understand that I should contact my treating physician if I have any questions regarding his/her potential financial interest in the ancillary services. I further understand that I am free to choose where I receive medical services and that I may discuss with my physician the availability of alternative treatment facilities if I so desire.

CONSENT FOR TREATMENT:

By signing this consent, I am authorizing my physician(s) and/or order another person to perform all exams, tests, procedures, injections, phlebotomy and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Dr. _____
With Total Health and Wellness or assigned physician in group unless revoked by me in writing and informed.

_____ Date: _____ / _____/ 20 _____

Patient Signature

Total Health and Wellness

OFFICE POLICIES

REFILL REQUESTS

Please allow 48 hours for refill. These request can be made by your pharmacy via fax or be left via voicemail. Please make sure that your pharmacy has the correct physician's information. Same day refill requests are not guaranteed.

All controlled substances will be given in person only and will generaly require an office visit. The Physician maintains the right to refuse any request for prestcriptions that are medically inappropiate or unecessary and they also maintain the right to require a patient visit prior to rendering any prescriptions.

REFERRAL REQUESTS

If your insurance company requires a referral from your primary care physician for appointments with any specialist or procedures please allow 5 to 7 business days for this to be processed. Once your insurance has approved the referral , you will receive a letter in the mail with the information necessary to schedule the appointment.

Referrals will only be approved once your doctor has deemed it medically necessary and after a doctors visit. The patient has a right to choose the specialist, however they must be in your insurance's network and it may delay the process for the referral. Please feel free to call the office to inquire about the status of your referral after 7 business days.

APPOINTMENT NO SHOW

Patients that no show to their appointments or do not cancel at least 24 hours in advanced will be charged a $20.00 fee.

PHONE CALLS

If you are trying to communicate with the office, please leave a message for questions and appointments. All phone calls will be returned within 24 hours.

FORMS AND LETTERS

There will be a $15 charge for all forms, letters and any other paperwork that will need to be completed by the physician.The physician will have the right to decline to do so if it not deemed medically necessary. The fee is to be paid prior to the completion of the forms. Please allow at least 72 hours for the completion, this includes but is nit limited to FMLA, Home Health Certifications, Drug Discounts and Temporary Leave Paperwork.

PATIENT PORTAL

Please give your email address so that we can provide you a link to access your lab results online.

Total Health And Wellness

RELEASE OF PATIENT INFORMATION

I CONSENT AND AUTHORIZE THE RELEASE OF ANY NORMAL OR ABNORMAL TEST RESULTS OR IMAGING RESULTS BY PHONE TO THE FOLLOWING PERSONS:

- ☐ MY SPOUSE:_____
- ☐ MY CHILDREN:_____
- ☐ MY PARENTS:_____
- ☐ OTHER:_____
- ☐ MY VOICEMAIL(PHONE NUMBER):_____

PRINTED NAME _____ DATE OF BIRTH_____

SIGNATURE:_____ DATE:_____

PATIENT RECORDS OF DISCLOSURE

IN GENERAL, THE HIPAA PRIVACY LAW GIVES PATIENTS THE RIGHT TO REQUEST ON USES AND DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION (PHI). THE PATIENT IS ALSO PROVIDED THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS OR THAT A COMMUNICATION OF PHI BE MADE BY ALTERNATIVE MEANS, SUCH AS SENDING CORRESPONDENCE TO AN OFFICE INSTEAD OF A HOME ADDRESS. THE INFORMATION WILL REMAIN IN EFFECT UNTIL REVOKED IN WRITING BY THE INDIVIDUAL.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY)

- ☐ HOME TELEPHONE_____
- ☐ OK TO LEAVE MESSAGE WITH DETAILES INFORMATION
- ☐ LEAVE NAME/DOCTOR WITH CALLBACK NUMBER ONLY
- ☐ WORK TELEPHONE_____
- ☐ LEAVE DETAILED MESSAGE ON WORK VOICEMAIL
- ☐ LEAVE NAME/DOCTOR WITH CALLBACK NUMBER ONLY
- ☐ WHEN UNABLE TO CONTACT ME BY PHONE, A WRITTEN COMMUNICATION MAY BE SENT TO MY HOME ADDRESS
- ☐ OTHER_____

PATIENT NAME:_____ DOB_____

PATIENT SIGNATURE:_____ DATE_____

HEALTHCARE PROVIDERS MUST KEEP RECORDS OF PHI DISCLOSURES. INFORMATION PROVIDED WILL BE DOCUMENTED ON THE TEST RESULT, PROGRESS NOTE OR PAATIENT COMMUNICATION IN QUESTION.