Express Family Clinic

Spring:
610 Rayford Rd, Ste. 644
Spring, TX 77386

Conroe:
16145 Hwy 105 W, Ste. 600
Montgomery, TX 77356

New Caney:
12073 N Grand Parkway E, Ste. 200
New Caney, TX 77357

PATIENT REGISTRATION FORM

NAME: LAST _____ FIRST _____ MI ____ **DOB:** _____ **SEX:** M or F

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

HOME PHONE NUMBER: _____ **CELL PHONE NUMBER**: _____

EMPLOYER: _____ **WORK PHONE NUMBER:** _____

EMERGENCY CONTACT: _____ **PHONE NUMBER:** _____

ALLERGIES: __NO KNOWN ALLERGIES __OTHER: _____

REASON FOR VISIT TODAY: _____ **DATE OF ONSET OF SYMPTOMS:** _____

CURRENT MEDICATIONS: PLEASE LIST **ALL** PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS (INCLDING VITAMINS AND SUPPLEMENTS): (MEDICATION/DOSE/HOW OFTEN) _____
_____
_____

LIST ALL CURRENT AND PAST MEDICAL HISTORY: __Headaches __High Blood Pressure __Arthritis __Bone/Joint Disease __Prostate Disease __Gastritis/Ulcer __Depression/Anxiety __Diabetes __HIV __Asthma/COPD __Chest Pain/Heart Disease __Hepatitis __Gout __Cancer __Other: _____

HAVE YOU HAD SURGERY IN THE PAST? __NO __YES **TYPE/DATE:** _____
_____

FAMILY HISTORY: (CHECK ALL THAT APPLY) __HEART DISEASE __STROKE __ARTHRITIS __OSTEOPOROSIS __ALZHEIMER'S __GOUT __CANCER (TYPE) _____ OTHER: _____

(FEMALES) ARE YOU PREGNANT? __YES __NO DATE OF LAST MENSTRUAL CYCLE? _____

DO YOU SMOKE/CHEW TOBACCO? __YES __NO __CIGARETTES _____PACKS/DAY __ CIGARS_____PER DAY

DO YOU USE RECREATIONAL DRUGS? __YES __NO IF YES, TYPE: _____

DO YOU DRINK ALCOHOLIC BEVERAGES? __YES __NO IF YES, HOW OFTEN? __SOCIALLY __RARELY __DAILY

HOW DID YOU HEAR ABOUT EXPRESS FAMILY CLINIC? _____

FINANCIAL AGREEMENT

Payment is due in full at the time of service. Acceptable methods of payment are cash, debit and/or credit card.

I understand that my insurance policy is a contract between myself and my insurance company; *Express Family Clinic* is not involved in billing to your insurance company. If I have questions or concerns regarding my coverage for office visits, procedures, lab work, medications, or particular conditions, I am responsible for obtaining this information. I agree to pay in full for all services if I choose to have the service provided.

HIPAA

Express Family Clinic upholds the standard of the HIPAA laws. As a patient, we want you to know:

- We respect the privacy of your personal medical records and will do all we can to secure and protect that privacy.
- When it is appropriate and necessary, we provide the minimum information to only those in need of your health care information, treatment, payment or health care operations, in order to provide health care that is in your best interest.
- You may refuse to consent to the use or disclosure of your personal health information, but *this must be in writing*.
- Under this law, we have the right to refuse to treat you should you refuse to disclose your Personal Health Information (PHI). This information is critical in making appropriate medical decisions.

If you have any questions regarding this consent, please speak with one of the staff of *Express Family Clinic*.

TREATMENT CONSENT AND AUTHORIZATION

I consent to medical screening and medical examination to determine my current health status, other medical evaluations, diagnostic procedures, routine care, and medical treatments which the medical and professional staff of *Express Family Clinic* may deem necessary, advisable, or appropriate. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of the procedures and/or treatments.

I have read the above information and consent that it is correct to the best of my knowledge. My signature here indicates compliance with the above policies.

_____ _____

Signature of Patient/Guardian Date