6402 Louetta Rd. #140
Spring, TX 77379
Tel. (281) 251-8700
Fax: (281) 251-8701

PATIENT REGISTRATION FORM

LAST NAME: _____ **FIRST NAME**: _____ **MI** _____ **DOB:** _____

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

CELL PHONE NUMBER: _____ **ALTERNATE PHONE NUMBER**: _____

EMAIL ADDRESS: _____

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

❒ **NO KNOWN ALLERGIES** **ALLERGY TO:**_____

REASON FOR VISIT TODAY: _____

CURRENT MEDICATIONS: Please list **ALL** prescription, non-prescription medication, over the counter meds, vitamins, supplements, herbal remedies

_____

_____

(FEMALES ONLY) ARE YOU PREGNANT? YES NO IDK **Date of last menstrual cycle?** _____

PAST MEDICAL HISTORY: (circle) Headaches High Blood Pressure High Cholesterol Arthritis Bone/Joint Disease Gastritis/Ulcer Depression Anxiety Diabetes HIV Asthma COPD Chest Pain Heart Disease Hepatitis Gout Prostate disease Cancer
Other: _____

HAVE YOU EVER HAD SURGERY? YES NO **Year/Type:** _____
_____

FAMILY HISTORY: (circle) Heart Disease High Blood Pressure Diabetes Stroke Arthritis Osteoporosis Alzheimer's Gout Thyroid Disease Cancer
Other: _____

Do you smoke, vape, or use tobacco products? YES NO Vape Cigarettes _____Packs per day Cigars____Per day Chew/Dip

Do you use recreational drugs or marijuana of any type? YES NO IF YES, Which drugs?_____

Do you drink alcoholic beverages? YES NO IF YES, How often? RARELY DAILY WEEKLY MONTHLY

How did you hear about Access Health Clinic? _____

FINANCIAL AGREEMENT

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

I understand that my insurance policy is a contract between myself and my insurance company; *Access Health 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

Access Health 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.

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 *Access Health 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