Demographics

First: ___________________________ Middle: ___________________________ Last: __________________________________

DOB: ___________________________ SSN: _____________________________ Male/Female/Transgender

Race: _______________________ Marital Status: ___________________________ Language: ___________________________

Address: ____

City: ___________________________________ State: __________________ Zip: _______________________

Home: ________________________________ Cell: ________________________________ Work: ______________________________

Email: ____

Preferred Pharmacy: ____

Emergency Contact:

Name: ____ Relation: ____

Phone: ______________________________________ Email: ____

For Minors:

Parent/Guardian: ____ DOB: ____

Phone: ____ Email: ____

Other/Referring Physicians:

Physician	Specialty	Contact

Patient History Form

Current Medications			
Medication	Dosage	Directions	For?

Allergies: ____

____

Past Medical History:

	Hypertension		Sleep apnea		Emphysema/COPD		Colon polyps
	High cholesterol		Depression		Tuberculosis		Ovarian cysts
	Heart disease		anxiety		Acid reflux/GERD		Irregular menses
	Diabetes		Macular degeneration		Stomach Ulcers		Hepatitis C
	Blood clot		Epilepsy		Gallstones		Kidney stones
	Stroke		Cataracts		Liver Disease		UTIs
	Seizures		STDs		Diverticulitis		Kidney disease
	Asthma		headaches/migraines		Hemorrhoids		Arthritis
	Lupus		Gout		Psoriasis		Osteoporosis
	Thyroid disorder		Anemia		Neck disorder		Back disorder
	Allergies		HIV/AIDS		Cancer		Mental illness

Other (Please specify):____

____

Social History:

	Yes	Sociably	No	Used to (Quit)	Please Specify:
Alcohol					
Tobacco					
Recreational Drugs					
Caffeine					

Employment Status	
Occupation?	
Adopted?	
Number of Children	
Sexually Active?	

Family History:

Condition	**Y/N**	**Relation**	**Condition**	**Y/N**	**Relation**
Diabetes			Mental Illness		
Heart Disease			Anxiety		
Heart Attack			Depression		
HTN			Stroke		
Kidney Disease			Cholesterol		
Cancer (Please specify):					

Other (Please specify):____

____

Patient History Continued

Surgical History:

Surgery	Date	Physician	Facility

Hospitalizations:

Date	Hospital	Reason

Current Supplements & Nutriceuticals:

Supplement	Dosage	Date Started

Patient Responsibilities

When your insurance is verified, the benefits given are not a guarantee of payment. Insurance will decide whether the item, visit, procedure, etc. is deemed medically necessary and will only do so after the claim has been submitted. It is your responsibility as the patient to call your insurance for all questions or disagreements you may have with the policy benefits related to our office. You have the right to ask for benefit coverage before any procedure is performed in the office that may cost you an additional charge. The prices given are only an estimation of benefit coverage. If the insurance denies a claim and the cost exhausts all appeal efforts, then you as the patient will be responsible for the cost. If you have any questions or concerns regarding coverage, feel free to contact the office and your insurance company.

- Copay and/or all non-covered services are due at the time of your service. This fee cannot be billed to you.

Initial: _______________

- There will be a $50 charge for all disability forms and FMLA forms, and a minimum fee of $25 for all medical records or letters. Please allow two weeks for the completion of these forms, records, or letters. All forms or requests must be given to the front office staff directly.

Initial: _______________

- We require a 24-hour notice for cancelling or rescheduling an appointment, or a $25 fee will be applied to the patient's account. This also applies to "no show" appointments. There will be a $35 fee for any returned checks along with any associated bank fees.

Initial: _______________

I have read the above patient responsibilities and agree to comply, and I accept the responsibilities for any payment that becomes due as outlined above.

Patient Name: _______________________________________

Patient signature: ___________________________________ Date: ____________________________

Medical Release Authorization for Patient Medical Records

Legal Name: ______________________________ DOB: ______________________________

Address: ___________________________ City/State/Zip: _________________________________

Home: _______________________ Cell: ______________________ Work: ______________________

I request and authorize the release of my patient medical records FROM the office of:

Physician Name: ____

Address: ____________________________ City/State/Zip: ________________________________

Phone: ______________________________ Fax: ____________________________________

Please release my medical records TO the office of:

Please Mail to:
M. Moon, S. Calaway

616 Elm St., Portland, TX, 78374

If less than 50 pages
Fax to: 361-977-2047

___ All Medical Records

___ Other: ____

Please include this form when mailing or faxing back medical records.

___ I do NOT consent to the release of my personal and mental health information, which may include the following: all personal health information related to sexually transmitted disease(s), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), as well as information about behavioral or mental health services, and/or treatment for alcohol and/or drug abuse.

This request is valid for 365 days after the signed date.

Patient or Guardian Signature: ____

Date: _________________________________