



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						Employment Status	
Tobacco						Occupation?	
Recreational Drugs						Adopted?	
Caffeine						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 & Nutraceuticals:

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 TO the office of:

Physician Name: _____

Phone: _____ Fax: _____

Please release my medical records FROM the office of:

Please Mail to:
Bridge Family Practice

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

921 Houston St., Portland, TX, 78374

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 Name: _____

Date: _____