JKR FAMILY MEDICINE
JAMES KEITH ROLAND. MD

Personal Information

Name (First):_____ **(MI):**_____ **(Last):**_____
DOB: ___/___/____ **Sex**: M( ) F( ) **SSN**: _____-____-_____
Address: _____ **City:** _____ **Zip:**_____
Home Phone: (___)____-____ **Cell Phone**: (___)____-____
E-mail: _____
Employer:_____**Occupation**:_____
Circle One: Retired | Disabled | Unemployed

Ethnicity: Hispanic/ Latino | Not Hispanic/ Latino | I prefer not to respond

Race: American Indian/ Alaskan Native | Native Hawaiian/ Other pacific Islander | Black/ African American | Asian | White / Caucasian | Other:_____
I prefer not to respond (_)

Marital Status: Single | Married | Divorced | Widowed | Separated

Emergency Contact
Name: _____
Relation: Spouse | Child | Sibling | Parent | Other: _____
Phone Number: (___)____-_____

Advanced Directives
Power of Attorney (POA) | Living Will | Do Not Resuscitate | Other:_____

Insurance(s) **Self Pay (_____)**
Carrier:_____ Member ID: _____ Group # _____
Carrier:_____ Member ID: _____ Group # _____

Patient Signature: _____
Date: _____

950 Hilltop Dr. Suite 102
Weatherford, TX 76086
Phone: (682)499 - 3800
Fax: (682)499 - 3801

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Medical History

No Known Drug/ Food Allergies (___)

Drug/ Food	Reaction(s)

Recent Hospitalizations NONE(___)

Year	Reason

Surgical History NONE(___)

Year	Reason

Patient Signature:

_____

Date:

_____

Medical/ Family History NONE(___)

Please check the corresponding box
if you or your family have any of the following:

	Yourself	**WHICH** family member?
High Blood Pressure		
Low Blood Sugar		
Diabetes		
COPD		
Heart Condition		
Heart Attack		
Seizures		
Cancer		
Stroke		
Depression/Anxiety		
High Cholesterol		
Asthma		
Thyroid Condition		
Kidney Condition		
Liver Condition		
GERD/ Acid Reflux		
Migraines		
Back Pain		
Other:		

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Medical History (Continued)

Tobacco History NONE(___)

Smoker: Yes(_) No(_)
Chewing Tobacco Yes(_) No(_)
How many cigarettes per day? _____
Do you smoke every day? Yes (_) No (_)
How soon after you wake up do you smoke?
_____
Are you interested in quitting? Yes(_) No(_)
Ex-Smoker: Yes (_) No(_)
When did you quit?_____

Alcohol History NONE(___)

Alcohol: Yes (_) No(_)
How often?
_____
How Much? _____
Do you ever consume more than 6 alcoholic beverages in one occasion? Yes (_) No (_)
Recreational /Street Drugs:
Yes (__) No (__)
_____

OB/GYN History NONE (___)

Last Menstrual Period:_____ How many times have you been pregnant?_____
How many live births?_____
Do you have a history of miscarriages: Yes (_) No (_) How Many?_____
Spontaneous Abortions: Yes (_) No (_) _____ Elective Abortions: Yes (_) No (_) _____
Still born births: Yes (_) No (_) _____ Other Comments:_____

Current Medication NONE (_____) Pharmacy: _____
SEE ATTACHED COPY OF PERSONAL MED LIST (_____)

Medication	Strength	How Many	How Often	Who Prescribed?

Patient Signature: _____
Date: _____
Provider Signature: _____

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Patient Policy

James Keith Roland. MD works on an appointment/ walk in basis. Appointments should be made for all services provided. We understand that illnesses and emergencies do come up. Walk-In appointments are available and will be worked in between scheduled appointments.

If you arrive more than 15 minutes late for your appointment, we may ask you to reschedule or wait until the next available appointment time in order for the clinic to stay on schedule. **If you are late or miss more than 3 scheduled appointments, you may be discharged from this clinic**. If you need to cancel or change your appointment, please call 24 hours in advance. Another patient may need to be seen at that time. We ask that you bring either your medications or a medication list with you to each visit. Please promptly notify our office should your address, phone number, name or insurance change.

New Patients

New patients should arrive at least 20-25 minutes before their scheduled appointment time to fill out any remaining paperwork. It is especially important that new patients bring with them their medications or medication list, proof of insurance, and some acceptable form of ID.

Medication Refills

If you need your medications to be refilled please call our office. **Please allow 24-48 hours for medications to be refilled. DO NOT** wait until you are out or only have one pill left to call our office for refills. **NO CONTROLLED SUBSTANCE MEDICATIONS WILL BE REFILLED BY PHONE.** You must **MAKE AN APPOINTMENT** with our office for controlled medication refills.

No-Show / Cancellations

Failure to show for more than 3 scheduled appointments without notice (a "no-show") will result in your discharge from this clinic. If you need to cancel your appointment, please call us 24 hours in advance.

Financial Responsibility

ALL patients are expected to pay at the time of service. Please make yourself aware of your insurance policy requirements as we do verify your policy information prior to your visit. Should you have a change in insurance, it is important to notify our office and supply us with new insurance cards as soon as possible. A driver's license number is required for all checks. **There is a $30 fee for returned checks.** After 2 returned checks you will not be allowed to give checks at this clinic.

By signing below, I acknowledge that I have read, understand, and agree to the above policy.

Patient Signature:_____Date:_____

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HIPPA Waiver

I understand that my health information is private and confidential. I understand that James Keith Roland, MD works in every way to preserve the confidentially of my personal health information.

I understand that signing this document means that James Keith Roland, MD may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. Failure to sign this consent may result in the healthcare provider declining to provide care.

James Keith Roland, MD has a detailed document called the Notice of Privacy Practices. It contains more information about the policies and practices used to protect their patient's privacy. I understand that I have the right to read this notice before signing this agreement.

James Keith Roland, MD may update the Notice of Privacy Practices, if I ask, James Keith Roland, MD will provide me with the most current Notice of Privacy Practices.

Under the terms of this consent, I can ask James Keith Roland, MD to restrict how my personal health information is used or disclosed to carry out treatment, payment or healthcare operations. I understand that James Keith Roland, MD does not have to agree with my request. If James Keith Roland, MD does not agree to my request, I understand that James Keith Roland, MD will follow the agreed upon limits.

By signing below, I acknowledge that I have read, understand, and agree to the above policy.
Patient Signature:_____Date:_____

I understand that I have the right to cancel this consent in writing at any time. If I do cancel this consent, I understand that James Keith Roland, MD may have already used or disclosed information about me and canceling this consent would not affect the information already used or disclosed.

Would you like to designate someone to receive your medical information (test results, appointments, referrals, etc.)? _____YES _____NO

Name: _____Phone:_____

_____by initialing here you are allowing us to call and leave messages on the phone numbers listed in your personal information on file.

_____by initialing here you are allowing us to send correspondence to the address listed in your personal information on file.

Prescription History Consent

I hereby give consent to James Keith Roland, MD providers to obtain my prescription history from any pharmacy / Texas Controlled Substance Data Base that has dispensed any medications to me for purpose of establishing my treatment history.

Patient Signature and Date:_____

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Authorization and Informed Consent for Release of Medical Record Information

Patient Name: _____DOB: _____

Name of Person or Organization **RELEASING** Medical Record Information:

_____

Name of Person or Organization **TO RECEIVE** Medical Record Information:

_____**JAMES KEITH ROLAND, MD**_____

Include the following Reports or Documents from the Medical Records Dated:

- History & Physical
- Discharge Summary
- Operative Reports
- Lab Reports/ Results
- Radiology Reports
- Other: _____

The Purpose or Need for Disclosure is

- ❷ Medical Treatment
- ❷ Patient Request
- ❷ Billing or Claim Payment
- ❷ Other: _____

I authorize and give consent to the above mentioned, to release the above stated information to the identified person or organization. I understand that the information to be released may include information pertaining to the diagnosis and or treatment of mental illness, alcoholism, drug dependence, a disability, or HIV test result. I understand that written notification is necessary to cancel this consent and that I may cancel this consent at any time except to the extent that information to be released as a result of this authorization. I understand that I have the right to inspect and/or receive a copy of the information to be released as that I may be charged a fee for any copies of the medical records that I receive. This authorization is to remain in effect for 6 months from the date of signature, unless otherwise stated. A copy of this authorization shall be as valid as the original.

_____ _____ **OR** _____

Date Patient Signature Legal Guardian/ Guarantor Signature

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