SERENE BOLD HEALTH CLINIC LLC

4606 FM 1960 W, Ste 224, Houston TX, 77069
Email: Serenebold@sereneboldhealthclinic.com
Phone: 281-944-5692
Fax: 281-944-5693

NEW PATIENT FORM

Patient's Name_____ Sex ☐ M ☐ F
Patient's Date of Birth: _____/_____/_____ SSN*_____/_____/_____*REQUIRED
Ethnicity: ☐ Hispanic or Latino ☐ NOT Hispanic or Latino ☐ OTHER_____
☐ Refused to Provide Ethnicity
Home Telephone Number: (_____) _____ Cell Number: (_____) _____
Mailing Address: _____
City: _____ State: _____ Zip code: _____
Employer: _____ Work Number: (_____) _____
Spouse's Name: _____ Phone Number: (_____) _____
Pharmacy Preference: Name/Location and Phone #_____
Language Preference*:_____*IF OTHER THAN ENGLISH
Email Address: _____

RESPONSIBLE PARTY INFORMATION (If patient is under the age of 18)

Name: _____
Relationship to Patient: _____
Date of Birth: _____/_____/_____ SSN*_____/_____/_____*REQUIRED
Mailing Address: _____City: _____State: _____Zip code: _____
Employer: _____ Work Number: (_____) _____

INSURANCE INFORMATION

Primary Insurance: _____
Subscriber's Name: _____Date of Birth: _____/_____/_____
Subscriber SSN: _____/_____/_____* * IF other than patient.
Subscriber relationship to patient: ☐ SPOUSE ☐ PARENT ☐ OTHER_____

Secondary Insurance: _____
Subscriber's Name: _____Date of Birth: _____/_____/_____
Subscriber SSN: _____/_____/_____* * IF other than patient
Subscriber relationship to patient: ☐ SPOUSE ☐ PARENT ☐ OTHER_____

EMERGENCY CONTACT

Name: _____Phone Number: (_____) _____
Relationship to Patient: _____

I certify that all the information given by me is correct to the best of my knowledge.
I agree to notify changes to my contact and insurance information.

Signature: _____ **Date:** _____/_____/_____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

You have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended.

This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). I voluntarily request a mid level provider (Nurse Practitioner) and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that
(1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and
(2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

Consent is hereby given to Serene Bold Health Clinic provider and its employees to provide medical services and fullfill Nurse practitoner orders, retrieve and review my medical record/electronic medical record which includes my medication list and other medical information necessary to facilitate electronic prescribing.

You have the right to discuss the treatment plan with your provider about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I certify that all the information given by me which includes my name, address, telephone number,and insurance information are correct to the best of my knowledge and that I am authorized to inform Serene Bold Health Clinic of any changes immediately.

I hereby authorize Serene Bold Health Clinic to furnish information to insurance carriers, referring physicans/mid level providers, and other healthcare agencies concerning illness and treatment with respect to services rendered.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

FINANCIAL RESPONSIBILITY

Our office is pleased to accept your insurance assignment, as soon as your exact coverage is verified.We will file your claim forms and assist you in every way we can. However, it must be fully understood that the contract is between you and your health insurance company and you are fully responsible for any amount not paid by your insurance.

Office policy regarding insurance assignment:
A CREDIT CARD/DEBIT CARD WILL BE SAVE ON FILE FOR THE FOLLOWING PURPOSE
1. Your insurance should pay within 30 days. If your insurance has not paid within 60 days, you may be responsible for the balance, and be reimbursed when and if your insurance pays.
2. Our office does NOT guarantee that your insurance will pay. We will make every attempt to receive insurance payment. However, if for some reason, your insurance claim is denied, you are responsible for the FULL amount of your bill.
3. Our office will NOT enter into a dispute with your insurance company over a claim. This is your responsibility and obligation.

I assign all payment for services rendered to Serene Bold Health Clinic. I understand and agree that I am responsible for all charges whether or not covered by my insurance.

NOTICE OF SEPARATE BILLING

Serene Bold Health Clinic provider may order laboratory and/or radiology services as part of your treatment plan.

You will recieve a separate bill for lab and radiology services from the facility that performed or processed these tests and not through our office.

Please be advised that some insurance companies mandate where your lab tests can be performed.

The provider in this facility may be in-network with your insurancecompany but Laboratory/radiology company may not be. The same may be true with LabCorp or other outside laboratories that your insurance does not cover.

Some insurance companies may also apply lab and/or x-ray charges to your deductible.

If you have questions as to whether your charges will be managed in this manner, please consult with your insurance company.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed Name of Patient or Personal Representative Relationship to Patient

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Patient Name_____
Date of Birth_____

☐ **CHECK HERE IF NO INFORMATION CAN BE RELEASED TO FAMILY/FRIENDS**

Limited Release of Information to Family/Friends for Physician Clinics

I give my permission to SERENE BOLD HEALTH CLINIC to share certain personal health information about me with the individuals listed below. These individuals will only be given information about me that is related to their involvement in my care or payment for my care. I understand that I am not required to complete this form in order to obtain health care.

Name: _____ Phone Number: _____

Relationship: _____ Talk to this person about (*check each box that applies*):

☐ Any non-sensitive[2] information regarding my health care or payment for my health care.

OR

☐ Only these things:

	My appointments – scheduling & reminders		My test results
	My after visit summary (AVS)		My bills
	Other:		

Serene Bold Health Clinic may leave phone voice-mails using your phone number on file that pertains to

☐ Any non-sensitive[2] information regarding my health care or payment for my health care.

OR

☐ Only these things:

	My appointments – scheduling & reminders		My test results
	My after visit summary (AVS)		My bills
	Other:		

If I change my mind about the people or the contact information I have listed in this form, I will complete a new form with such changes.

_____DATE: _____
PATIENT SIGNATURE (or Authorized Representative)

PRINTED NAME & RELATIONSHIP (if not patient): _____

[1] This form is not a substitute for a health care power of attorney or other formal designation of an individual authorized to make health care decisions for you if you are not able. If an individual listed above is your guardian or agent (under a power of attorney), or is otherwise authorized by law to act on your behalf, your health care provider may share as much of your personal health information with that person as the law permits.

This form is not a substitute for a valid HIPAA compliant written authorization when it is required to release copies of medical and billing records or information.

[2] Non-sensitive information excludes mental health, alcohol and substance abuse, HIV and other communicable diseases, and genetic testing. **This form is not considered sufficient authorization to release sensitive information.**

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YOUR HEALTH INFORMATION PRIVACY RIGHTS

Notice of Privacy Practices

Federal law sets rules for health care providers and health insurance companies about who can look at and receive our health information. This law, called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), gives you rights over your health information, including the right to get a copy of your information, make sure it is correct, and know who has seen it.

You can ask to see or get a copy of your medical record and other health information. If you want a copy, you may have to put your request in writing and pay for the cost of copying and mailing.

You can ask to change any wrong information in your file or add information to your file if you think something is missing or incomplete.

By law, your health information can be used and shared for specific reasons not directly related to your care, like making sure doctors give good care, reporting when the flu is in your area, or reporting as required by state or federal law. In many of these cases, you can find out who has seen your health information.

You can:
Learn how your health information is used and shared by your doctor or health insurer. Generally, your health information cannot be used for purposes not directly related to your care without your permission. For example, your doctor cannot give it to your employer without your written authorization.

Let your providers or health insurance companies know if there is information you do not want to share. You can ask for other kinds of restrictions, but they do not always have to agree to do what you ask, particularly if it could affect your care.

Finally, you can also ask your health care provider not to tell your health insurance company about care you receive or drugs you take, if you pay for the care or drugs in full and the provider does not need to get paid by your insurance company.

Acknowledgement of Receipt of Notice of Privacy Practices

The Notice of Privacy Practices is a complete description of my rights as a patient of Serene Bold Health Clinic.
By signing below, I am stating I have received the Serene Bold Health Clinic Notice of Privacy Practices.

PATIENT SIGNATURE: _____ DATE:_____
(or authorized representative)

PRINTED NAME:_____ TIME:_____

RELATIONSHIP, if not patient:_____

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NEW PATIENT MEDICAL HISTORY FORM

Full Name: _____ Date: _____

Birth Date: _____ Age: _____

ALLERGIES ❑ NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS *(Please list ALL)*	DOSE *(Mg., pill, etc.)*	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information

HEALTH MAINTENANCE SCREENING TEST HISTORY

CHOLESTEROL	Date:	Facility/Provider:	Abnormal Result? Y N
COLONOSCOPY/SIGMOID	Date:	Facility/Provider:	Abnormal Result? Y N
MAMMOGRAM	Date:	Facility/Provider:	Abnormal Result? Y N
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? Y N
BONE DENSITY	Date:	Facility/Provider:	Abnormal Result? Y N

VACCINATION HISTORY

Last Tetanus Booster or TdaP:	Last Pnuemovax *(Pneumonia)*:
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine *(Shingles)*:	

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PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer *(type:_____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

SURGERIES

TYPE *(specify left/right)*	DATE	LOCATION/FACILITY

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: _____ Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

Patient Name: _____ DOB: _____

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FAMILY MEDICAL HISTORY ❑ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

✔ CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer (type:_____)	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other:_____	Other:_____	Other:_____
Mother																		
Father																		
Brother																		
Sister																		
Child																		
MGM																		
MGF																		
PGM																		
PGF																		
Other:_____																		

SOCIAL HISTORY

Occupation *(or prior occupation)*:	❑ Retired ❑ Unemployed ❑ Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift? Y N N/A	
Marital Status *(check one)*: ❑ Single ❑ Partner ❑ Married ❑ Divorced ❑ Widowed ❑ Other:_____	
Do you have children? Y N	If yes, how many?

OTHER HEALTH ISSUES

TOBACCO USE	Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)*		
Current: Packs/day _____ # of Years _____	***Past:*** Quit Date: _____ Packs/day _____ # of Years _____		
Other Tobacco *(check one)*: ❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew			
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	❑ Beer ❑ Wine ❑ Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N	Have you ever used needles to inject drugs? Y N		
Have you ever taken someone else's drugs? Y N			

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OTHER HEALTH ISSUES continued...

SEXUAL ACTIVITY	Sexually involved currently? Y N *(If no sexual history, please continue to Exercise)*	
Sexual partner(s) is/are/have been: ❑ Male ❑ Female		
Birth control method: ❑ None ❑ Condom ❑ Pill/Ring/Patch/Inj/IUD ❑ Vasectomy		
EXERCISE	Do you exercise regularly? Y N *(If you answered no, please move to Sleep)*	
What kind of exercise?	***Duration:*** How long (min.): _____ How often: _____	
SLEEP	How many hours, on average, do you sleep at night *(or during the day, if working night shift)*?	
DIET	How would you rate your diet? ❑ Good ❑ Fair ❑ Poor	Would you like advice on your diet? Y N
SAFETY	Do you use a bike helmet? Y N	Do you use seat belts consistently? Y N
Working smoke detector in home? Y N		If you have guns at home, are they locked up? Y N
Is violence at home a concern for you? Y N		Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y N

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other:_____		
Other:_____		

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military? Y N	If yes, how long and what branch?
Were you deployed? Y N	If yes, where?

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REVIEW OF SYSTEMS ✔ CHECK ALL THAT APPLY

	CONSTITUTION		CARDIOVASCULAR		SKIN
	Activity change		Chest pain		Color change
	Appetite change		Leg swelling		Pallor
	Chills		Palpitations		Rash
	Diaphoresis		**Gastrointestinal**		Wound
	Fatigue		Abdominal distention		**ALLERGY/IMMUNO**
	Fever		Abdominal pain		Environmental allergies
	Unexpected weight change		Anal bleeding		Food allergies
	HEAD, EAR, NOSE & THROAT		Blood in stool		Immunocompromised
	Congestion		Constipation		**NEUROLOGICAL**
	Dental problem		Diarrhea		Dizziness
	Drooling		Nausea		Facial asymmetry
	Ear discharge		Rectal pain		Headaches
	Ear pain		Vomiting		Light-headedness
	Facial swelling		**ENDOCRINE**		Numbness
	Hearing loss		Cold intolerance		Seizures
	Mouth sores		Heat intolerance		Speech difficulty
	Nosebleeds		Polydipsia		Syncope
	Postnasal drip		Polyphagia		Tremors
	Rhinorrhea		Polyuria		Weakness
	Sinus pressure		**Genitourinary**		**HEMATOLOGIC**
	Sneezing		Difficulty urinating		Adenopathy
	Sore throat		Dysuria		Bruises/bleeds easily
	Tinnitus		Enuresis		**PSYCHIATRIC**
	Trouble swallowing		Flank pain		Agitation
	Voice change		Frequency		Behavior problem
	EYES		Genital sore		Confusion
	Eye discharge		Hematuria		Decreased concentration
	Eye itching		Penile discharge		Dysphoric mood
	Eye pain		Penile pain		Hallucinations
	Eye redness		Penile swelling		Hyperactive
	Photophobia		Scrotal swelling		Nervous/anxious
	Visual disturbance		Testicular pain		Self-injury
	RESPIRATORY		Urgency		Sleep disturbance
	Apnea		Urine decreased		Suicidal ideas
	Chest tightness		**MUSCULAR**		
	Choking		Arthralgias		
	Cough		Back pain		
	Shortness of breath		Gait problems		
	Stridor		Joint swelling		
	Wheezing		Myalgias		
			Neck pain		
			Neck stiffness		

Patient Name: _____ DOB: _____