MMH FAMILY HEALTH CLINIC - PATIENT INFORMATION

PATIENT NAME: _____
(LAST) (FIRST) (MIDDLE) (MAIDEN) (NICKNAME)

Date of Birth: _____ Social Security Number: _____ Marital Status: M S D W Sex: M F

Race: CAUCASIAN BLACK HISPANIC ASIAN INDIAN

Mailing Address: _____ City: _____ State: _____ Zip Code:_____

Home Phone: _(____)_____-_____ Cell Phone:_(____)_____-_____ Work Phone: __(_____)_____-_____

Employer/Occupation: _____

Do you have a primary Doctor? Yes or No If yes, answer below:

Name of Doctor: _____ Phone Number: _____

Address: _____

If you do not have a primary doctor, are you wanting to establish a primary doctor at our facility? Yes or No

SPOUSE -IF PATIENT IS MINOR, GO TO SECTION B

Spouse Name:_____
(LAST) (FIRST) (MIDDLE) (MAIDEN) (NICKMANE)

Date of Birth: _____ Social Security Number: _____

Mailing Address: _____ City: _____ State: _____ Zip Code:_____

Home Phone: _(____)_____-_____ Cell Phone:_(____)_____-_____ Work Phone: __(_____)_____-_____

Employer/Occupation: _____

B. MINOR

FATHER'S NAME:_____
(LAST) (FIRST) (MIDDLE) (NICKMANE)

Date of Birth: _____

Address (if different from above): _____

Mailing Address: _____ City: _____ State: _____ Zip Code:_____

Home Phone: _(____)_____-_____ Cell Phone:_(____)_____-_____ Work Phone: __(_____)_____-_____

Employer/Occupation: _____

Work Address:_____

MOTHER'S NAME:_____
(LAST) (FIRST) (MIDDLE) (MAIDEN) (NICKMANE)

Date of Birth: _____

Address (if different from above): _____

Mailing Address: _____ City: _____ State: _____ Zip Code:_____

Home Phone: _(____)_____-_____ Cell Phone:_(____)_____-_____ Work Phone: __(_____)_____-_____

MMH FAMILY HEALTH CLINIC
CONSENT TO TREAT

AUTHORIZATION OF CARE

I authorize the staff of the MMH Family Health Clinic (MMH FHC) to render medical/surgical treatment, examinations, diagnostic procedures, or clinical services prescribed by the medical staff, their assistants, or their designees as necessary in the medical staff's judgment.

DISCLOSURE OF REQUIRED HIV/AIDS TESTING

Texas law authorizes a physician to require that a patient be tested for possible exposure to the Human Immunodeficiency Virus, the virus associated with AIDS, in the following situations: (1) if a health care worker is accidentally exposed to a patient's blood or body fluids, such as through a needle stick; or (2) if a medical or surgical procedure is to be performed with could expose health care workers to the patient's blood or body fluids. This disclosure is to inform you that you may be tested if any of these situations occur while in our office.

LAB/DIAGNOSTIC SERVICES

I understand that I may receive a separate bill if my medical care includes services which need to be sent to the Muenster Memorial Hospital. This is to include any co-pay or balance due for these services.

Patient Name:_____

Signature:_____ Date:_____

If patient is a minor or patient is unable to sign or give consent:

Responsible Party Name:_____

Responsible Party Signature:_____ Date:_____

- Parent
- Guardian
- Spouse
- Other _____

MMH Family Health Clinic

Patient Consent and Acknowledgment of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Muenster Hospital District (MHD) creates and maintains health records and other information described among other things, my health history, symptoms, examination, test results, diagnosis, treatment, and any plans of future care or treatment.

I have been provided with a Notice of Private Practice that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and Practices, and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations(quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, ect.) and the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of Protected Health Information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records whether written, oral or in electronic format; are confidential and cannot be disclosed for reasons outside or treatment, payment or healthcare operations without prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is a valid as this original.
3. I have the right to request that the use of my protected health Information, which is used or disclosed for the purpose of treatment, payment, health care operations, can be restricted. I also understand the District and I must agree to any restrictions in writing that I request on the use and disclosure of my protected information and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

Disclosures to Friend and/or Family Members

Do you want to designate a family member or other individual with whom the provider may discuss your medical condition?

(Circle one) YES or NO

I give permission for my Protected Health Information to be disclosed for purpose of communicating results, findings, and care decisions to the family and/or friend listed below:

Name Relationship Contact Information

1. _____
2. _____
3. _____
4. _____

May we leave a message regarding test results ect. On (circle): Cell -Voice mail/ Home- Voice mail

Phone Number(s) _____

_____

Print Patient Name Date

_____

Patients Signature or Guardian of Minor Signature Date of Birth

MMH Family Health Clinic
Private Pay Agreement

I understand MMH Family Health Clinic is accepting me as a private pay patient for the period of _____, and I will be responsible for paying for any services I receive. The provider **will not file a claim** to Medicaid or any other insurance for services provided to me.

It will be my responsibility to provide a copy of my current Medicaid card and/or other insurance information. Upon receipt, the provider will then file my claims. This information must be received within 30 days.

Signed: _____

Date: _____

MMH Family Health Clinic

Patient Information Update

Name _____ Date of Birth _____

- Since your last visit, has your address or phone number changed? Yes or No
  If yes, please undated necessary information: _____
- What pharmacy do you use? _____
- Since your last visit to our office, were you admitted to the hospital? Yes or No
  - If yes, please write where and when: _____
  - For what reason were you admitted: _____
  - What was your admitting doctors name: _____
- Since your last visit to our office, have you had any medical tests? Yes or No
  - Check any that apply:

__ Mammogram __ Pap Smear __ Colonoscopy
__ Blood word __ X ray __ EKG/ECG
__ Vision Test __ CT __ DEXA (bone test)
__ MRI __ Other_____

- Since your last visit to our office have you developed any new allergies or had a bad reaction to a medication or food? Yes or No
  - If yes, please describe: _____
- Since your last visit to our office, have you seen a specialist (such as a doctor for diabetes, heart, kidneys, cancer, eyes, gynecology, ect.) Yes or No
  - If yes, please describe: _____

Specialist Reason for visit Date

_____

_____

- Since your last visit to our office, have you had any vaccinations (shots)? Yes or No
  - If yes, Check the shots you received: __ Flu __ Tetanus __Pneumonia

Other (please list) _____

- Since your last visit to our office, have you started any new prescription medications? Yes or No
  - If yes, please list

Medication Dose How often

_____

_____

_____

_____

_____

MMH Family Health Clinic

Patient Medical History

Name _____ Date of Birth _____

Reason for Visit _____

__ Scarlet Fever	__ Pneumonia	__ Measles	__ Rheumatic Fever
__ Liver Disease	__ Unconscious Episodes	__ Diabetes	__ High Blood Pressure
__ Kidney Disease	__ Anemia	__ Tuberculosis	__ Allergies
__ Gallbladder	__ Cancer	__ Asthma	__ Thyroid Disease

List all surgeries, Date of those surgeries, and who performed those surgeries:

Check if there is any family history of any of the following diseases:

__ Heart Disease
__ Thyroid Disease
__ Kidney Disease
__ Cancer
__ Mental/Psychiatric Illness
__ Congenital Disease
__ Allergies
__ Tuberculosis
__ High Blood Pressure
__ Diabetes

If you checked any of the above, please explain relationship of family member, if they are living or deceased, and age:

Circle any current or previous habits:

Tobacco:	Yes	No	If yes, how much per day_____	For how long _____
Alcohol:	Yes	No	If yes, how much per week _____	For how long _____
Recreational Drugs:	Yes	No	If yes, what kind _____	For how long _____
Caffeine:	Yes	No	If yes, how much per day _____	What kind _____

Medications:

Please list all of the medications you are taking routinely, and as needed (include all prescription drugs, over the counter medications, herbal medications, and vitamins)

MMH Family Health Clinic

Patient Medical History

Name _____ Date of Birth _____

What is your current weight _____

Is your current weight your normal: Yes or No

If no what is your normal weight _____

Female patients:

What age did your menses begin ____

How often do you have a cycle ____

Last Pap smear ____

Last Mammogram ____

Number of Pregnancies ____

Number of Live Births ____

Number of Miscarriages ____

Number of Abortions ____

Type of birth control used _____

How long have you been on your current birth control_____

Please Circle any of the following symptoms that apply to you and describe in detail on the lines provided below:

Poor Appetite	Nausea	Vomiting
Heartburn	Trouble Swallowing	Abdominal Pain
Blood in Stool	Black Stool	Hemorrhoids
Jaundice	Constipation	Diarrhea
Bloating	Belching	Shortness of Breath
Chest Pain	Fast Heart Rate	Change in Bowel Habits
Excess Phlegm	Coughing Up Blood	Fever
Chills	Increased Sweating	Sneezing
Cough	Leg Pain While Walking	Sinus Pressure
Headache	Stiff Neck	Muscle Weakness
Back Pain	Ear Pain	Eye/Vision Changes
Tremors (Shaking)	Paralysis or Numbness	Trouble Sleeping
Nervous Tension	Fainting	Convulsions
Tingling in Hands and Feet	Dizziness	Depression
Anxiety	Enlarged Glands	Warmer then Normal
Colder than Normal	Increased Thirst	Increased Urination
Weight Change	Blood in Urine	Night Time Urination

Immunizations:

Please list the date of last immunization:

Tetanus _____

Hepatitis B _____

Pneumococcal (pneumonia) _____

Influenza _____

All other immunizations up to date: Yes or No

Allergies: Please list all Medication and Food allergies:

Medication or Food

Type of Reaction

Additional information you would like your provider to know?

MMH Family Health Clinic

Insurance Information

We file Medicare, Medicare Secondary, such as AARP, Universal, Medicaid, and MOST Private Insurances. We request copay payment at the time of service on all private insurances we will give you a super bill with diagnosis and paid charges for you to file with your insurance company if you wish to submit the charges. We are on some PPO programs and are trying to incorporate more into our patience. Please ask if we are on you particular insurance program.

If you have insurance cards with you we will photo copy them and you will not have to fill out this paper. We do ask that you read and sign the bottom of this page.

Insurance Company: _____

Insurance Address: _____

Insurance Phone Number: _____

Named of Insured: _____

Relationship to You: _____ Social Security Number of Insured: _____

Address of Insured: _____

Group Number: _____ Policy Number: _____

In your Insurance through your Employer? Yes or No

Employer's Name: _____

Employer's Address: _____

Employer's Phone Number: _____

Assignment of Benefits:

I authorize payment of medical benefits to MMH Family Health Clinic for services rendered

Signature _____ Date _____

Release of Information:

I authorize the release of any medical information necessary for the processing of any claims.

Signature _____ Date _____