BROOKSHIRE FAMILY PRACTICE

NEW PATIENT REGISTRATION FORM

(Please print)

Today's Date: / /	Date of your appointment: / /	Primary Care Physician:

PATIENT INFORMATION

Patient's last name: First: Middle:		Date of birth: / /	Age:	Sex: □ M □ F
Name you preferred to be called:	Social Security no:	Marital Status: □ Single □ Mar □ Div □ Sep □ Wid □ Partn		
Race: □ White □ Black □ Amer. Indian □ Asian □ Hawaiian □ Other		Ethnicity: □ Not Hispanic/Latino □ Hispanic/Latino □ Decline to answer		
Home ph no:	Cell ph no:	Email:	Preferred contact method: □ Home □ Cell □ Email	
Street address:		City:	State:	ZIP Code:
Preferred pharmacy name: Pharmacy address: Pharmacy number:		**How did you hear about us?** □ Facebook □ Our Website □ Internet search □ Friend/Family □ Dr. _____ □ Other: _____		
Employer:	Employer/Work phone no:	Occupation (if student please specify):		
Spouse/Partner Name:		Spouse/Partner Sex: □ M □ F □ Other: _____		
Reason For Visit:		Symptoms:		

FINANCIAL INFORMATION

(This section only applies to 18 years of age and under)

If you are under 18, person responsible for bill:	Birthdate: / /	Address (if different):	Home phone no: ( )
Is this person a patient here? □ Yes □ No			
Employer:	Employer/Work phone no:	Occupation (if student please specify):	

IN CASE OFEMERGENCY

Name of local friend or relative to contact in an emergency:	Relationship to patient:	Home phone no: ( )	Cell phone no: ( )
Sign:	Date:		

Brookshire Family Practice Communication

Appointment Reminds:

I wish to be reminded of upcoming appointments via:

□ HOME PHONE (call)	□ CELL PHONE (call)	□ EMAIL	□ TEXT

Authorization to release medical information:

In the event you must be contacted by phone with regards to appointments, test results, referrals, or any other reason, please indicate how you wish to be contacted.

Phone Number:_____ Is it ok to leave a message?____Yes_____No

Do you want Brookshire Family Practice, and all employees thereof, to be able to determine financial matters or medical care with any family members or emergency contacts? This permission will be valid indefinitely and must be revoked in writing. If so, please specify who and which information, below.

You may discuss my financial matters or medical care with the following:

INFORMATION OK TO DISCUSS	NAME	RELATIONSHIP	PHONE NUMBER
□ FINANCIAL □ MEDICAL			

Patient Consent for use and disclosure of protected health information:

With your consent, Brookshire Family Practice may use and disclose protected health information (PHI) about you to carry out treatment, payment and health care operations (TPO). You have the right to review our Notice of Privacy Practices prior to signing this contract. We reserve the right to revise our Notice of Privacy Practices at any time.

With your consent, Brookshire Family Practice may call, email or send mail to your home or office and leave a message about any items that assist the practice in carrying our TPO such as appointment reminders, insurance items and any call pertaining to your clinical care.

You have the right to request that we restrict how we use or disclose your PHI to carry out treatment, payment and health care operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound by our agreement.

By signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment, payment and health care operations. This consent may be revoked in writing except to the extent that we may have already made disclosures in reliance upon your prior consent.

If you decline to sign this consent, we may decline to provide treatment for you.

_____ _____

(Patient's Printed Name) (Signature of patient or legal guardian)

_____ _____

Relationship to patient, if other than self. Date

Patient Questionnaire

Name:_____ **Date:**_/____/_____

INSTRUCTIONS: This questionnaire will help your doctor better understand problems that you may have. Your doctor may ask you more questions about some of these terms. Please make sure to check a box for every item.

During the PAST MONTH, have you OFTEN been bothered by ...

	YES	NO
1. Back pain?	☐	☐
2. Pain in your arms, legs or joints?	☐	☐
3. Menstrual pain/problems?	☐	☐
4. Irregular periods?	☐	☐
5. Pain or problems during sexual intercourse?	☐	☐
6. Headaches?	☐	☐
7. Chest pain?	☐	☐
8. Dizziness?	☐	☐
9. Fainting Spells?	☐	☐
10. Feeling your heart pound or race?	☐	☐
11. Shortness of breath?	☐	☐
12. Constipation, loose bowels or diarrhea?	☐	☐
13. Need to get up at night to urinate regularly?	☐	☐
14. Nausea, gas or indigestion?	☐	☐
15. Feeling tired or low energy?	☐	☐
16. Trouble sleeping?	☐	☐
17. The thought that you have a serious, undiagnosed disease?	☐	☐
18. Your eating being out of control?	☐	☐
19. Little interest or pleasure in doing things?	☐	☐
20. Feeling down, depressed or hopeless?	☐	☐
21. Nerves, or feeling anxious or on edge?	☐	☐
22. Worrying about a lot of different things?	☐	☐
23. Have you had an anxiety attack, unreasonable feeling of fear or panic?	☐	☐
24. Thoughts you should cut down on your drinking of alcohol?	☐	☐
25. Anyone complaining about your alcohol use?	☐	☐
26. Feeling of guilt or anger about your drinking?	☐	☐

Overall, would you say your health is:
(Please choose one)

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

Other pertinent health information:

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	AGE		AGE		AGE
ADD/ADHD	____	Diabetes	____	Rheumatologic Disease	____
Anemia	____	Depression	____	Seizures	____
Anxiety	____	Emphysema	____	Stroke	____
Arthritis	____	Erectile Dysfunction	____	Substance Abuse	____
Asthma/Allergies	____	Fibromyalgia	____	Other (Please specify below):	
Atrial Fibrillation	____	Gallstones	____	_____	
Blood Clot	____	Gout	____	_____	
High Blood Pressure	____	Heart Attack	____	_____	
Cancer	____	Heartburn/Reflux	____	_____	
High Cholesterol	____	Kidney Disease	____	_____	
COPD	____	Liver Disease	____	_____	

• Immunizations: (Date) Tetanus____HPV_____Pneumonia_____Shingles_____Hepatitis B_____Meningitis_____

• Recent medications and dosages (include laxatives, antacids, aspirin):_____

_____

• Allergies (medications, pollens, foods, etc.):_____

• How often do you exercise?_____• How long do you exercise?_____• What are your hobbies?_____

• How is your sleep?_____ • How is your diet?_____

• Alcohol (average # of drinks per day):_____• Recreational drug use(include type & age):_____

• Have you ever smoked? Y N • How long?___•How Much?_____•Tried to stop smoking? Y N • Quit Date:_____

FEMALE PATIENTS ONLY.

•Number of pregnancies?___•Number of live births?___•Number of living children?____•Pregnancy complications?_____

• Serious injuries, illnesses or hospitalizations (Age):_____

_____

•Operations:(Age)_____

•Last Pap:_____ •Abnormal Pap tests: Y N •Contraception(Type): _____
•Last Mammogram:____

Check if anyone in your family has ever had the following:

	Relationship		Relationship		Relationship
□ Diabetes	_____	□ Stroke	_____	□ Gout	_____
□ High Blood Pressure	_____	□ Migraine Headaches	_____	□ Asthma	_____
□ Anemia	_____	□ Obesity	_____	□ Arthritis	_____
□ Heart Disease	_____	□ Thyroid Disease	_____	□ Mental Illness	_____
□ Cancer(type)	_____	□ Elevated Cholesterol	_____	□ Allergies	_____
□ Bleeding Disorder	_____	□ Kidney Disorder	_____	□ Other	_____

	IF LIVING		IF DECEASED			IF LIVING		IF DECEASED	
	Age	State of Health	Age	Cause		Age	State of Health	Age	Cause
Mother	___	_____	____	_____	Sister	___	_____	____	_____
Father	___	_____	____	_____	Husband/wife	___	_____	____	_____
Brother(s)	___	_____	____	_____	Children	___	_____	____	_____

Rights and Responsibilities

You Have ARight:

- To be treated with respect, consideration and dignity always.
- To receive assistance in a responsible manner
- To receive information about your health including your diagnosis, treatment, testing or procedures and medical alternatives including associated risks that may be involved in your healthcare.
- To know the identity and professional status of individuals providing services to you.
- To expect that your medical records and communications will be treated in a confidential manner.
- To refuse treatment and be advised of the alternative and likely consequences of your decision.
- To express a complaint to the Administrator, and/or Physician.

You Have A Responsibility:

- Patients will be required to pay for all services provided at the time services are rendered.
- To treat all office personnel respectfully and courteously.
- To keep scheduled appointments and to notify the office promptly if you will be delayed or unable to keep an appointment.
- To pay all charges services at the time of your visit, unless prior arrangements have been made.
- To ask questions and seek clarification until you fully understand the care you are receiving.
- To follow the advice of your medical provider and consider the alternatives and/or likely consequences if you refuse to comply.
- To provide honest and complete information to those providing medical care.
- To express your opinions, concerns, or complaints in a constructive and appropriate manner.

I have read and understand the office policy as stated above

_____ _____

(Patient's Printed Name) (Signature of patient or legal guardian)

_____ _____

Relationship to patient, if other than self. Date

Financial Policy and Administrative Services Fee

Patient Name:_____

We are committed to meeting your healthcare needs. Our goal is to keep your insurance and financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask you to adhere to the following guidelines and choose a plan that meets your needs:

1. It is your responsibility to provide us with your current address and telephone number at each visit. **Initial** ____
2. All services provided in our facility **MUST TO BE PAY IN FULL** at the time of your visit. **Initial** _____
3. You are ultimately responsible for payment for services you receive from our office. Any non-payment, including non-payment and returned checks will result in a $35 billing fee in addition to the balance owed. **Initial** _____
4. Cancelling an appointment less than 24 hours in advance or no showing an appointment will result in the following charges: $20 for a regular office visit, annual physical, Laboratory visit or any other schedule appointments. *3 late cancellations or no-shows in one year may result in your dismissal from our practice.* **Initial** _____
5. The vast majority of prescription refill requests will require an office visit. **Initial** _____
6. For new patients, the initial visit fee is $100 (excluding any additional services). Once you are registered, the offices visit is $75. This fee excludes any additional services such us, urine drug screening, laboratory test, completion on forms, among others. **Initial** ___
7. In some case, complex visit may result in additional fees due the number of topics that need to be addressed and length of the visit. The extra fee is $35. **Initial** _____

I acknowledge the terms of the financial policy and administrative service fee. I understand that failure to comply with the policies may result in my dismissal from Brookshire Family Practice.

_____ _____

(Patient's Printed Name) (Signature of patient or legal guardian)

_____ _____

Relationship to patient, if other than self. Date