

BRIDLEWOOD FAMILY HEALTHCARE

Patient Registration Form

PATIENT INFORMATION

Date: _____

Name: _____

DOB: _____

Address 1: _____

Address 2: _____

City, State, Zip: _____

Phone # () Home () Work () Cell: _____

Phone # () Home () Work () Cell: _____

Social Security #: _____

() Single () Married () Other _____ () Male () Female

Employer: _____

Phone #: _____

Address: _____

City, State, Zip: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone #: _____

Address: _____

City, State, Zip: _____

GUARANTOR

() Same As Patient

Name: _____

Address: _____ Relationship to Patient: _____

City, State, Zip: _____ Social Security #: _____

DOB: _____ Employer w/ Phone #: _____

PRIMARY INSURANCE INFORMATION

() Same as Patient () Same as Guarantor () Other

Insured Party: _____ Relationship to Patient: _____

Insured Phone#: _____ Social Security #: _____

Company: _____

Insured DOB: _____

Bridlewood Family Healthcare, P.A.
PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE ____/____/____

DATE OF LAST PHYSICAL EXAM ____/____/____

LAST NAME _____ FIRST NAME: _____

SOCIAL SECURITY No. _____ DATE OF BIRTH: ____/____/____ AGE _____

OCCUPATION. _____ MARITAL STATUS MARRIED SINGLE DIVORCED WIDOWED

Medical (*High Blood Pressure, Diabetes, Asthma, Cancer, Heart Disease, etc.*)

Surgical (*Tonsillectomy, Appendectomy, Hysterectomy, Hernia, etc.*) None

Allergies to medications? None (If Yes, please explain type of reaction, i.e. hives, wheezing, upset stomach, swelling, etc.)

Current prescription medicines				Current prescription medicines			
Name of drug	mg dose	# tablets	# times per day	Name of drug	mg dose	# tablets	# times per day
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

OTC medicines. (Aspirin, Tylenol, Ibuprofen, Aleve, vitamins and herbals.)

Family History

Father: Living - Age: ____ Deceased, Age at Death ____ (Cause) _____

Mother: Living - Age: ____ Deceased, Age at Death ____ (Cause) _____

Siblings: Number Living ____ Number deceased ____ (Cause) _____

List other illnesses in your family (Example - Diabetes, heart disease, colon cancer, breast cancer, prostate cancer, etc)

Family Member	Illness	Family Member	Illness	Family Member	Illness
_____	_____	_____	_____	_____	_____

Social History

Smoke? Yes No If yes, how much? ____ # of packs/day ____ # of years When did you stop smoking? _____

Alcohol? Yes No If yes, how much? _____

Exercise regularly? Yes No If yes, what and how frequently? _____

Routinely wear **seatbelts?** Yes No Routinely wear a **helmet?** Yes No Substance Abuse? Yes No

Review of Symptoms

Are you currently experiencing any problems related to the following symptoms? write **Yes** or **No**.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other _____		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other _____		

Allergic/Immunologic

Hay Fever	Y	N
Drug allergies	Y	N
Other _____		

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other _____		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other _____		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other _____		

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N

Last Eye & Dental Exam

Date - Last Eye Exam: _____

Date - Last Dental Exam: _____

Screening Exams

Cholesterol _____ Colonoscopy _____

PSA _____ Chest X-ray _____

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other _____		

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other _____		

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problem	Y	N
Other _____		

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other _____		

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other _____		

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Other _____		

Psychologic

Are you generally satisfied with your life? Y N

Do you feel severely depressed? Y N

Have you considered suicide? Y N

Sexual History

Change in sex drive? Y N

Sexual performance satisfactory? Y N

Other (i.e. sexual trauma) _____

Mammogram _____

Stress Test _____

Pelvic Exam _____

Blood Pressure _____

PATIENT FINANCIAL POLICY AGREEMENT

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance with our billing personnel or our office manager, all copays and deductibles are due at the time services are rendered. Your insurance company dictates that the patient is responsible for their copay each and every time an appointment is scheduled unless other arrangements have been made. Additional financial responsibility maybe determined after your insurance claim has been processed. For your convenience we accept Visa, MasterCard, Discover, American Express, checks & cash. NSF checks will incur a \$30.00 fee which will be added to your account balance.

PATIENT INSURANCE

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. This office's policy is to collect this co-payment when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

MINOR PATIENTS

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment. All patient under the age of 18 will not be seen without a parent or guardian present/or without a signed consent form on file.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

Print patient name

Date

Patient Signature

Date

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Bridlewood Family Healthcare for medical services rendered to my-self and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Bridlewood Family Healthcare to: (1) release any information necessary to insurance carriers regarding my illness and/or treatments: (2) process insurance claims generated in the course of examination or treatment: and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Bridlewood Family Healthcare on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature

Date

Witness

Date

Bridlewood Family Healthcare, P.A.

Acknowledgement of Receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed this office's Notice of Privacy Practices which explains how my medical Information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

Name of Patient: (Print)

Signature of Patient

Date

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient

Patient Consent for Disclosure of Information

I authorize the release of my protected health information to the following person(s):

NAME: _____

ADDRESS: _____

PHONE: _____

RELATION TO PATIENT: _____

Limitations on the information you may release subject to this Release Form are as follow: _____

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records.
Initial: _____ Date: _____

I DO NOT AUTHORIZE THE RELEASE OF MY INFORMATION TO ANYONE

Patient Signature (or Parent, Guardian, or Legal Representative) Date

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) listed above

Medical Records Release Form

Medical Record Release Requested From:

Doctor's Office: _____

Address: _____

Phone Number: _____

Fax Number: _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

**Bridlewood Family Healthcare
3400 Long Prairie Road Suite 200
Flower Mound, TX 75022
972-899-6300
972-899-6020 (Fax)**

Limitations on the information you may release subject to this Release Form are as follows: _____

The reason or purposes for this release of information are as follows: _____

Patient Name: _____ **DOB:** _____

Signature of Patient (Parent, Guardian, or Legal Representative): **Date:**

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

I DO NOT WISH TO HAVE MY RECORDS RELEASED