CLAUDE FAMILY MEDICAL CLINIC

PATIENT INFORMATION

Name_____ Today's Date_____

Physical Address_____ PO Box_____

City_____ State_____ Zip Code_____

Date of Birth_____ SS#_____

Driver's License #_____ State_____

Male_____ Female_____ Married_____ Single_____ Race_____

Home Phone #_____ Work/Cell Phone #_____

Employer_____ Occupation_____

Parent/Spouse Name_____

Parent/Spouse Employer_____ Parent/Spouse Cell #_____

Parent/Spouse Work #_____

Emergency Contact Name_____ Phone #_____

INSURANCE INFORMATION: COPY OF INSURANCE CARD REQUIRED

Insured Name_____ SS#_____

Date of Birth_____ Relationship_____

Employer_____ Group #_____ ID #_____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my health care provider to submit claims for benefits, services rendered, or services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed each particular claim.

I _____ hereby authorize my insurance carrier to pay and hereby assign directly to CLAUDE FAMILY MEDICAL CLINIC all benefits if any other wise payable to me for services. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits when received by and paid to CLAUDE FAMILY MEDICAL CLINIC will be credited to my account in accordance with the above assignment.

FAMILY HISTORY

Please mark a **P=Parent G=Grandparent**
S=Sibling C=Child beside each if it applies

CANCER/BLD DISORDER:_____
DIABETES:_____
HIGH BLOOD PRESSURE:_____
HEART DISEASE:_____
ASTHMA:_____
STROKE:_____
THYROID:_____
KIDNEY:_____
LUNG DISEASE:_____
ARTHRITIS:_____
GLAUCOMA:_____
PSYCH:_____

ALCOHOL/SMOKING

Drinks/week:_____
Packs/day:_____

Last PAP:_____
Mammo:_____

Flex-sig/Colonscopy:_____
PSA:_____

Flu Vaccine: Y N
Date:_____

Pneumonia Vaccine: Y N
Date:_____

Last Tetanus:_____

ALLERGIES

_____

_____

_____

_____

CURRENT PROBLEMS

Date: **Problem:**

_____

_____

_____

_____

HOSPITALIZATIONS/SURGERIES

Date:_____
Reason:_____
Doctor:_____
Hospital:_____

Date:_____
Reason:_____
Doctor:_____
Hospital:_____

Date:_____
Reason:_____
Doctor:_____
Hospital:_____

Date:_____
Reason:_____
Doctor:_____
Hospital:_____

CURRENT MEDICATIONS

_____

_____

_____

_____

_____

CLAUDE FAMILY MEDICAL CLINIC
CONSENT TO TREATMENT

I hereby voluntarily consent to the performance of those routine diagnostic procedures, examinations and rendering of health care by the health care team at Claude Family Medical Clinic. I understand that my primary care may be provided by the physician or by a non-physician provider (Physician Assistant or Advanced Nurse Practitioner) specially trained and appropriately licensed by the State of Texas. I also understand that the non-physician provider practices under protocols (standards, regulations, and restrictions). Should my health care needs exceed protocols, non-physician provider will make appropriate referral to a physician in the field of my special needs.

I understand that I am an active member of my health care team.

RELEASE OF INFORMATION

I authorize the Claude Family Medical Clinic to release medical information about my treatment to other health care providers assigned to me.

_____ This includes HIV related information _____This does NOT include HIV related information

I have been offered the opportunity to ask questions about this form and I understand the contents.

Signature of patient/authorized guardian of patient Date

Witness Date

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

By signing below, I attest that I have been offered and have read the Notice of Health Information Privacy Practices for Claude Family Medical Clinic. I also attest that unless I specify by name below, my information will only be shared with myself, doctors providing treatment, and my insurance if applicable.

Signature of patient/authorized guardian of patient Date

I give Claude Family Medical Clinic permission to talk to the following people regarding my health care.

_____ _____

_____ _____