

# PATIENT REGISTRATION FORM

*Baylor Family Medicine at Keller*

FOR OFFICE USE ONLY

Acct # \_\_\_\_\_

Today's Date: \_\_\_\_\_

Patient Information

|   |                     |  |  |                   |
|---|---------------------|--|--|-------------------|
| Full Name: Last   |                     | First  | Middle   | (Maiden)          |
| Address: (Street or Box)  |                     | City   | State  | Zip               |
| Home Phone #<br>( )   | Work Phone #<br>( ) | Cell Phone #<br>( )  | Email Address  |                   |
| Sex (check one)<br><input type="checkbox"/> Male <input type="checkbox"/> Female  | Date of Birth       | Age  | Social Security #  | Drivers License # |
| Occupation  | Employer            | Employer Address   |  |                   |
| Marital Status (check one) <input type="checkbox"/> Married <input type="checkbox"/> Single<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated  |                     | Spouse's Name  | Race (check one) <input type="checkbox"/> American Indian<br><input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Other |                   |
| If Student, Indicate School   |                     | If Patient is a Minor, provide Name of Parent(s) or Legal Guardian (legal documentation required): |  |                   |
| Emergency Contact (not living at same address)  |                     |  | Emergency Contact Phone #<br>( )   |                   |
| How did you hear about the physician you are seeing today?<br><input type="checkbox"/> Physician Referral (5) Who? _____ <input type="checkbox"/> Other Professional (6) <input type="checkbox"/> Existing Patient (10)<br><input type="checkbox"/> Family (8) <input type="checkbox"/> Friend (1) <input type="checkbox"/> Word of Mouth (9) <input type="checkbox"/> Baylor Hospital (19) <input type="checkbox"/> Health Plan/Insurance Company (17)<br><input type="checkbox"/> Emergency Room (7) <input type="checkbox"/> Direct Mail (18) <input type="checkbox"/> 1-800-4-BAYLOR Referral Line (3) <input type="checkbox"/> Website/Internet (13) <input type="checkbox"/> Walk-In (4)<br><input type="checkbox"/> Newspaper Advertisement (15) <input type="checkbox"/> Radio/TV (16) <input type="checkbox"/> Event (11) <input type="checkbox"/> Location (14) <input type="checkbox"/> Yellow Pages (2) <input type="checkbox"/> Unknown (20) |                     |  |  |                   |

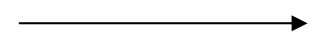
Responsible Party

|                           |                     |  |                   |                                   |
|---------------------------|---------------------|--|-------------------|-----------------------------------|
| Guarantor Full Name: Last |                     | First  | Middle            | (Maiden)                          |
| Address: (Street or Box)  |                     | City   | State             | Zip                               |
| Home Phone #<br>( )       | Work Phone #<br>( ) | Cell Phone #<br>( )  | Drivers License # |                                   |
| Date of Birth             | Age                 | Sex<br><input type="checkbox"/> Male <input type="checkbox"/> Female | Social Security # | Patient Relationship to Guarantor |
| Employer                  |                     | Employer Address   |                   |                                   |

Insurance Information

|   |              |   |  |                                       |                |
|---|--------------|---|--|---------------------------------------|----------------|
| Name of <b>Primary</b> Insurance Company  |              | Phone #<br>( )                            | Name of <b>Secondary</b> Insurance Company |                                       | Phone #<br>( ) |
| 1. Mailing Address                        |              |   | 2. Mailing Address                         |                                       |                |
| City                                      |              | State                                     | Zip  | City                                  |                |
| State                                     |              | Zip                                       | State                                      |                                       | Zip            |
| Policy Number                             | Group Number | Effective Dates of Policy<br>From:<br>To: |  | Policy Number                         | Group Number   |
| Effective Dates of Policy<br>From:<br>To: |              | Effective Dates of Policy<br>From:<br>To: |  |                                       |                |
| Policy Holder (if other than patient)     |              | Date of Birth                             |  | Policy Holder (if other than patient) |                |
| Date of Birth                             |              | Relationship to Patient                   |  | Date of Birth                         |                |
| Relationship to Patient                   |              | Relationship to Patient                   |  |                                       |                |
| Policy Holder's Employer                  |              | Work Phone #<br>( )                       |  | Policy Holder's Employer              |                |
| Work Phone #<br>( )                       |              | Work Phone #<br>( )                       |  |                                       |                |
| Employer Address                          |              |   | Employer Address                           |                                       |                |
| City                                      |              | State                                     | Zip  | City                                  |                |
| State                                     |              | Zip                                       | State                                      |                                       | Zip            |

(COMPLETE BACK OF FORM)





## HEALTHTEXAS PROVIDER NETWORK NOTICE OF HEALTH INFORMATION PRACTICES

### THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

#### **Understanding Your Health Record/ Information**

This notice describes the practices of HealthTexas Provider Network (HTPN) and that of its physicians<sup>1</sup> with respect to your protected health information created while you are a patient at HTPN. HTPN physicians and personnel authorized to have access to your medical chart are subject to this notice. In addition, HTPN physicians may share medical information with each other for treatment, payment or health care operations described in this notice.

We create a record of the care and services you receive at HTPN. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the records of your care at HTPN.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

#### **Your Health Information Rights**

Although your health record is the physical property of HTPN, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information for treatment, payment, health care operations and as to disclosures permitted to persons, including family members involved with

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<sup>1</sup> Physicians are employees of HealthTexas Provider Network and are neither employees nor agents of Baylor Health Care System, or Baylor Health Care System's subsidiary, community or affiliated medical centers.

your care and as provided by law. However, we are not required by law to agree to a requested restriction;

- Obtain a paper copy of this notice of information practices;
- Inspect and request a copy of your health record as provided by law;
- Request that we amend your health record as provided by law. We will notify you if we are unable to grant your request to amend your health record;
- Obtain an accounting of disclosures of your health information as provided by law;
- Request communication of your health information by alternative means or at alternative locations. We will accommodate reasonable requests; and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken in reliance on your authorization.

You may exercise your rights set forth in this notice by providing a written request, except for requests to obtain a paper copy of the notice, to the Compliance Officer at HealthTexas Provider Network, 8080 North Central Expressway, Suite 1700, LB 83, Dallas, TX, 75206.

#### **Our Responsibilities**

In addition to the responsibilities set forth above, we are also required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you;

- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on certain uses and disclosures;
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change. Should our information practices change we are not required to notify you, but we will have the revised notice available for you to request at HTPN. The revised notice will also be posted at HTPN offices and on the Baylor Health Care System web page at [www.baylorhealth.edu](http://www.baylorhealth.edu); and
- We will not use or disclose your health information without your written authorization, except as described in this notice.

#### **Examples of Disclosures for Treatment, Payment, Health Care Operations and As Otherwise Allowed By Law.**

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information should fall within one of the categories.

*We will use your health information for treatment.*

**For example:** We may disclose medical information about you to

doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at HTPN. We may share medical information about you in order to coordinate different treatments, such as prescriptions, lab work and x-rays. We may also provide your physician or a subsequent health-care provider with copies of various reports to assist in treating you once you are discharged from care at HTPN.

*We will use your health information for payment.*

**For example:** A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

*We will use your health information for regular health care operations.*

**For example:** We may use the information in your health record to assess the care and outcome in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

*We will use your health information as otherwise allowed by law. The following are some examples of how we may use or disclose medical information about you.*

**Business associates:** There are some services provided in our organization through agreements with business associates. Examples include answering services and copy services. To protect your health information, however, we require business associates to appropriately safeguard your information.

**Notification:** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

**Research:** We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to protect the privacy of your health information.

**Funeral directors:** We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

**Organ procurement organizations:** Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

**Communications for treatment and health care operations:** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Fundraising:** We may contact you as part of a fundraising effort.

**Food and Drug Administration (FDA):** We may disclose to the FDA health information relative to adverse events with respect to food, medications, devices, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

**Worker's compensation:** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**Public health:** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

**Abuse, neglect or domestic violence:** As required by law, we may disclose health information to a governmental authority authorized by law to receive reports of abuse, neglect, or domestic violence.

**Judicial, administrative and law enforcement purposes:** Consistent with applicable law, we may disclose health information about you for judicial,

administrative and law enforcement purposes.

**Required or allowed by law:** We will disclose medical information about you when required or allowed to do so by federal, state or local law.

### **For More Information or to Report a Problem**

If you have questions and would like additional information, you may contact the Baylor Health Care System Office of HIPAA Compliance at 1-866-245-0815.

If you believe your privacy rights have been violated, you can file a complaint with the Baylor Health Care System Office of HIPAA Compliance or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

**EFFECTIVE DATE: 02/01/06**  
**VERSION: 2**

Patient Name: \_\_\_\_\_ Patient Identifier: \_\_\_\_\_



**ACKNOWLEDGMENT OF THE RECEIPT OF  
HEALTHTEXAS PROVIDER NETWORK'S (HTPN) NOTICE OF HEALTH INFORMATION  
PRACTICES**

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

HTPN is furnishing you with the attached notice, which provides information about how HTPN and its physicians<sup>1</sup> may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. **By signing this form, you acknowledge that you have received a copy of HTPN's *Notice of Health Information Practices*.**

\_\_\_\_\_  
(Signature of Patient or Legal Representative)

\_\_\_\_\_  
(Date)

February 1, 2006  
(Effective Date of Notice)

<sup>1</sup>Physicians are employees of HealthTexas Provider Network and are neither employees nor agents of Baylor Health Care System, or Baylor Health Care System's subsidiary, community or affiliated medical centers.

# **AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize \_\_\_\_\_  
Entity/Person from whom records are requested; Include full name

\_\_\_\_\_  
Complete address,

\_\_\_\_\_  
City, State, ZIP, Telephone and Fax.

to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

Print Patient Name \_\_\_\_\_

Date of Birth 

|    |    |    |    |    |    |    |    |
|----|----|----|----|----|----|----|----|
|    |    |    |    |    |    |    |    |
| MM | MM | DD | DD | YY | YY | YY | YY |

 Social Security Number 

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|

Patient Address \_\_\_\_\_ Phone Number ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_

Date(s) of Service (if known) \_\_\_\_\_

Description of information to be released: ( Check  all that apply )

- |   |   |   |                                       |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Emergency Room     | <input type="checkbox"/> Radiology Reports    | <input type="checkbox"/> Admission / Registration | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Records                  | _____                                 |
| <input type="checkbox"/> Nurse's Notes      | <input type="checkbox"/> Physician's Orders   | <input type="checkbox"/> Laboratory Reports       | _____                                 |
| <input type="checkbox"/> Progress Notes     | <input type="checkbox"/> Operative Records    | <input type="checkbox"/> Billing Records          | _____                                 |
| <input type="checkbox"/> Discharge Summary  | <input type="checkbox"/> Radiology Films      |   |                                       |

Description of the purpose of the use and / or disclosure: \_\_\_\_\_

The health information described herein shall be released to: ( Check  the appropriate category )

- Hospital     Physician     Insurance Company     Attorney     Patient     Other

Name: Baylor Family Medicine at Keller \_\_\_\_\_

( Check  the appropriate delivery method )  
 Mail     Fax

Address: 601 S. Main Suite 200, Keller , TX 76248 \_\_\_\_\_

Pick-up Records

Phone Number: 817-753-6888 \_\_\_\_\_ Fax Number: 817.753.6885 \_\_\_\_\_

Other \_\_\_\_\_

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until \_\_\_\_\_ ( Expiration date / event ).

I further understand that I may revoke this authorization at any time by notifying this practice in writing at the address listed below. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient's Representative

PATIENT IDENTIFICATION NO. \_\_\_\_\_

PATIENT \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

## **BAYLOR FAMILY MEDICINE AT KELLER**

601 S. MAIN, SUITE 200  
Keller, Texas 76248

**AUTHORIZATION FOR RELEASE  
OF INFORMATION (Rev. 9/04)**

## **BAYLOR FAMILY MEDICINE AT KELLER Payment Policy**

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Please read the following payment policy and ask any questions you may have. Please sign in the space provided at the bottom. A copy will be provided to you upon request.

1. **Insurance** – We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is expected until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and Deductibles** – All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment and/or deductible amounts at each visit.
3. **Non-covered services** – Please be aware that some, and perhaps all, of the services you receive may not be covered or not considered reasonable or necessary by Medicare or of other insurers. You must pay for these services in full at the time of service.
4. **Proof of insurance** – All patients must complete our patient information form before seeing the doctor. We will request a copy of your driver's license and current insurance as identification. If you fail to provide us with the correct information in a timely manner, you may be responsible for payment.
5. **Claims submissions** – We will submit your claims and assist you in any reasonable way to help get your claim paid. You may need to provide your insurance company with information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays the claim. Your insurance benefit is contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes** – If your insurance changes, please notify us before your next visit so that the appropriate changes can be made to help you receive the maximum benefit. If your insurance company does not pay your claim in 45 days, you will receive a bill for the balance due.
7. **Non-payment** – If your account is over 90 days past due, we may refer your account to a collection agency unless payment arrangements are made.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Let us know if you have any questions or concerns.

**I have read and understand the payment policy and agree to abide by its guidelines.**

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**Signature patient/responsible party**

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**Date**

Patient Name: \_\_\_\_\_ Patient Identifier #: \_\_\_\_\_

## Patient Preference Regarding Communication of Health Information

### I. Who to Contact

I hereby give permission to **Baylor Family Medicine at Keller** to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_ I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

### II. How to Contact

I wish to be contacted in the following manner:

|  |  |
|--|--|
| Home Telephone:  | Work Telephone:  |
| <input type="checkbox"/> OK to leave message with detailed information | <input type="checkbox"/> OK to leave message with detailed information |
| <input type="checkbox"/> Leave message with call-back number only      | <input type="checkbox"/> Leave message with call-back number only      |

|   |
|---|
| <input type="checkbox"/> Written Communication                      |
| <input type="checkbox"/> OK to mail to my home address _____        |
| _____   |
| <input type="checkbox"/> OK to mail to my work/office address _____ |
| _____   |
| <input type="checkbox"/> OK to fax to this number _____             |
| _____   |

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

## **Electronic Communications to Patients**

Baylor Office EHR is a joint effort of HealthTexas Physician Network physicians and other physicians aligned with Baylor Health Care System to fully support an electronic patient care experience through implementation of a common electronic health record platform. HealthTexas Physician Network (“HTPN”) is pleased to offer Baylor Office EHR as a convenience to communicate electronically with you under the conditions and terms outlined below.

### Use of Electronic Communication from HTPN to the Patient

Please check the appropriate box below:

Yes, I want HTPN to communicate my information with me through a secure system that is designed to keep your information safe. You will be notified via email when there is secure information for you to review. The e-mail will provide a link that will take you to the secure site. After clicking on the link, you will be required to log-in and provide a password to access your information. You will need to make note of the password to access any future information.

Please enter in the space below the e-mail address you want to use to receive the notification that there is information awaiting your review:

**E-mail address:** \_\_\_\_\_.

In choosing your e-mail address, please consider the privacy implications; for example, any other person that may have access to your e-mail address or any other person, such as your employer, that may have the right and/or ability to review all e-mail received at your work address.

No, I do not want HTPN to use electronic communication as a way to communicate my information to me.

### HTPN E-mail Guidelines

- At this time, HTPN can only send e-mails *to* patients. Currently, HTPN is not able to *accept* patient e-mails.
- All e-mail you receive from HTPN is sent under the name and e-mail account of DFW Centricity.
- The patient is responsible to notify HTPN promptly of any changes to his/her e-mail address.
- All of HTPN’s electronic communications to you are recorded in your medical record. Those who have access to your medical record also have access to the e-mail messages sent to you.

### Confidentiality and Privacy

- If the electronic communication process described above is not used, we cannot guarantee the confidentiality of the information.
- HTPN will not share your e-mail address with anyone unauthorized to view your medical record.

### Consent and Agreement

*I have carefully reviewed this document and agree to fully comply with the guidelines defined herein for electronic communication from HTPN. I understand that the service will be offered at no charge and that I will be notified if and when a fee is administered for the service.*

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

Welcome!! Please take a moment to complete our Health History Form.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_ None Known

\_\_\_\_\_  
\_\_\_\_\_

Current Medications: \_\_\_\_\_ None

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Surgeries / Hospitalizations: \_\_\_\_\_ None

\_\_\_\_\_  
\_\_\_\_\_ Yr \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Yr \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Yr \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Yr \_\_\_\_\_

Social History: Live in \_\_\_\_\_

I'm originally from \_\_\_\_\_

Single Married Divorced Sep Wid (circle)

No. of Children \_\_\_\_\_ Occupation \_\_\_\_\_

Smoke now? \_\_\_\_\_ Previous smoker? \_\_\_\_\_

How many years total? \_\_\_\_\_ # Packs / day \_\_\_\_\_

If quit, when? \_\_\_\_\_ Do you drink alcohol? \_\_\_\_\_

If so, how much per week? \_\_\_\_\_

Any other drug use? \_\_\_\_\_

I was referred by: \_\_\_\_\_ Health Plan book / site

\_\_\_\_\_ Friend / Co-Worker \_\_\_\_\_ Doctor: \_\_\_\_\_

\_\_\_\_\_ Phone Book \_\_\_\_\_ Newspaper \_\_\_\_\_ Family

**Personal History:**

Please circle any of the following medical problems you have or have had:

- |                           |                      |
|---------------------------|----------------------|
| 1. Nasal allergies        | 26. Gout             |
| 2. High blood pressure    | 27. Kidney stones    |
| 3. High cholesterol       | 28. Hemorrhoids      |
| 4. Arthritis              | 29. Heartburn/reflux |
| 5. Heart Attack           | 30. Urine leakage    |
| 6. Chest pain             | 31. Changing moles   |
| 7. Stroke                 | 32. Leg swelling     |
| 8. Blood clot(s)          | 33. Emphysema        |
| 9. Back or neck pain      | 34. Seizures         |
| 10. Cancer _____          | 35. Insomnia         |
| 11. Asthma                | 36. AIDS or HIV+     |
| 12. Bronchitis            | 37. Bleeding problem |
| 13. Pneumonia             | 38. Eating disorder  |
| 14. Headaches / Migraines | 39. Prostate problem |
| 15. Dizziness / Fainting  | 40. Change in bowels |
| 16. Anxiety / Nerves      | 41. Weight change    |
| 17. Depression            | 42. Rheumatic fever  |
| 18. Shortness of breath   | 43. Vision loss      |
| 19. Heart Palpitations    | 44. Hearing loss     |
| 20. Heart Murmur          | 45. Persistent Cough |
| 21. Thyroid Problem       | 46. Genital Herpes   |
| 22. Anemia / Low Blood    | 47. Gonorrhea        |
| 23. Hepatitis A B C       | 48. Chlamydia        |
| 24. Ulcer(s)              | 49. Diabetes         |
| 25. Chemical Dependency   | 50. Abdominal pain   |
- Other: \_\_\_\_\_  
\_\_\_\_\_

**Family History:**

**Family Members**

- |                     |       |
|---------------------|-------|
| High Cholesterol    | _____ |
| Heart Disease       | _____ |
| High Blood Pressure | _____ |
| Stroke              | _____ |
| Diabetes            | _____ |
| Thyroid Disease     | _____ |
| Arthritis           | _____ |
| Epilepsy / Seizures | _____ |
| Mental Illness      | _____ |
| Glaucoma            | _____ |
| Breast Cancer       | _____ |
| Colon Cancer        | _____ |
| Prostate Cancer     | _____ |
| Ovarian Cancer      | _____ |
| _____               | _____ |

**Health Maintenance:**

Last Physical? \_\_\_\_\_

Last Mammogram? \_\_\_\_\_ Pap Smear? \_\_\_\_\_

Flu vaccine? \_\_\_\_\_ Pneumonia vaccine? \_\_\_\_\_

Tetanus booster? \_\_\_\_\_ Labwork? \_\_\_\_\_

**Thank you!!**

Welcome!! Please take a moment to complete our Health History Form.

Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Goes By: \_\_\_\_\_

Child's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Age/Date of Last Check-up: \_\_\_\_\_

Drug Allergies: \_\_\_\_None Known

\_\_\_\_\_

\_\_\_\_\_

Food Allergies? \_\_\_\_\_

Insect Bite Allergy? \_\_\_\_\_

Bad vaccine reaction? \_\_\_\_\_

Current Medications: \_\_\_\_None

\_\_\_\_\_

\_\_\_\_\_

Currently takes vitamins? Yes No

Surgeries / Hospitalizations: \_\_\_\_None

\_\_\_\_\_ Yr \_\_\_\_\_

\_\_\_\_\_ Yr \_\_\_\_\_

Social History: Lives in \_\_\_\_\_

Child is originally from \_\_\_\_\_

Has \_\_\_\_ brothers, \_\_\_\_ sisters, \_\_\_\_ pets.

Lives with \_\_\_\_ both parents \_\_\_\_ Mom \_\_\_\_ Dad

\_\_\_\_ Relative (\_\_\_\_) \_\_\_\_ Foster Parent

Parents are \_\_\_\_ Married \_\_\_\_ Separ. \_\_\_\_ Divorced

Current school: \_\_\_\_\_ Grade: \_\_\_\_\_

If teen, any \_\_\_\_ tobacco \_\_\_\_ alcohol use?

Any other drug use? \_\_\_\_\_

I was referred by: \_\_\_\_Health Plan book / site

\_\_\_\_ Friend / Co-Worker \_\_\_\_ Doctor: \_\_\_\_\_

\_\_\_\_ Phone Book \_\_\_\_ Newspaper \_\_\_\_ Family

Personal History: \_\_\_\_\_

Please circle any of the following medical problems you have or have had:

- |                            |                         |
|----------------------------|-------------------------|
| 1. Nasal allergies/sinus   | 26. Seizures            |
| 2. Hearing loss            | 27. Kidney stones       |
| 3. Eye/Vision problem      | 28. Urinary infections  |
| 4. Eczema / Hives          | 29. Heartburn/reflux    |
| 5. Serious Injury          | 30. Diabetes            |
| 6. Overweight              | 31. Changing moles      |
| 7. Underweight             | 32. Cancer _____        |
| 8. Chicken pox             | 33. Anxiety / Nerves    |
| 9. Frequent ear infections | 34. Depression          |
| 10. Abdominal Pain         | 35. Thyroid problem     |
| 11. Asthma                 | 36. High blood pressure |
| 12. Bronchitis             | 37. Bleeding/bruising   |
| 13. Pneumonia              | 38. Eating disorder     |
| 14. Headaches / Migraines  | 39. Scarlet fever       |
| 15. Dizziness / Fainting   | 40. Change in bowels    |
| 16. Throat infections      | 41. Weight change       |
| 17. Speech Problems        | 42. School problems     |
| 18. Lung Problems          | 43. High cholesterol    |
| 19. Heart Palpitations     | 44. Back or neck pain   |
| 20. Heart Murmur           | 45. Hepatitis A B C     |
| 21. Teeth problems         | 46. Mental Retardation  |
| 22. Anemia / Low Blood     | 47. Bedwetting          |
| 23. Heart Disease          | 48. Bad rash            |
| 24. Stomach Ulcer(s)       | 49. Behind on shots     |
| 25. ADD or suspected       | 50. Discipline problems |

Other: \_\_\_\_\_

Family History:

Family Members

- |                     |       |
|---------------------|-------|
| High Cholesterol    | _____ |
| Heart Disease       | _____ |
| High Blood Pressure | _____ |
| Anemia              | _____ |
| Diabetes            | _____ |
| Thyroid Disease     | _____ |
| Arthritis           | _____ |
| Epilepsy / Seizures | _____ |
| Mental Illness      | _____ |
| Asthma/Allergies    | _____ |
| Migraines           | _____ |
| Cystic Fibrosis     | _____ |
| Alcoholism          | _____ |
| Birth Defects       | _____ |
| _____               | _____ |

Health Maintenance: Do you have a copy of his / her shot record for? \_\_\_\_\_

Thank you!!



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Our doctors strongly believe in the prevention of disease and closely follow national recommendations of screening for cancer, heart disease, cholesterol problems, diabetes, high blood pressure, osteoporosis, and many vaccine-preventable diseases. Keeping your doctor up-to-date on your current health helps him / her keep you healthy. We ask that you take a moment before seeing the doctor to update us by answering a few questions below. Your medical assistant or nurse will collect this from you. Thanks!!

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

- 1. The tetanus vaccine prevents an often-fatal disease called lockjaw. Have you had a tetanus booster within the last 10 years? Yes\_\_\_ No\_\_\_ If yes, approx. what year? \_\_\_\_\_
- 2. When was your last flu vaccine? \_\_\_\_\_ Never have taken \_\_\_\_\_
- 3. Have you ever received the pneumonia vaccine? Yes\_\_\_ No\_\_\_ If yes, what year? \_\_\_\_\_
- 4. Have you had your cholesterol levels tested in the last 5 years, other than here in our office? Yes\_\_\_ No\_\_\_ If yes, roughly when was it done? \_\_\_\_\_
- 5. Do you currently use tobacco of any kind? Yes\_\_\_ No\_\_\_ If yes, how much in an average day? \_\_\_\_\_ How old were you when you started using tobacco? \_\_\_\_\_ Age today \_\_\_\_\_ If you used to use tobacco and then quit, approx. when did you quit? \_\_\_\_\_
- 6. If you are over the age of 50, have you ever had a colon cancer screening test? No\_\_\_ Yes, colonoscopy \_\_\_ Approx. what year? \_\_\_ Where was it done? \_\_\_\_\_ Yes, sigmoidoscopy \_\_\_ Approx. what year? \_\_\_ When was it done? \_\_\_\_\_ Yes, barium enema (lower GI x-ray) \_\_\_ Year \_\_\_ When was it done? \_\_\_\_\_ Yes, stool hemocult / guaiac cards (test for blood in the stool) Approx. year \_\_\_\_\_

**Male patients: Please skip to number 12.**

- 7. Do you perform regular self-breast exams? Yes\_\_\_ No\_\_\_
- 8. Approx. when and where was your last breast exam by a physician? \_\_\_\_\_
- 9. What was the approx. date of your last mammogram? \_\_\_\_\_ Never\_\_\_ Where did you have that mammogram done? \_\_\_\_\_
- 10. What was the approx. date of your last Pap smear? \_\_\_\_\_ Where done? \_\_\_\_\_
- 11. If you are of childbearing age and have a uterus, when was your last period? \_\_\_\_\_
- 12. Men and women can silently develop bone thinning / weakening with age. Have you ever had a bone density test done? Yes\_\_\_ No\_\_\_ If yes, approx. when? \_\_\_\_\_
- 13. Today, do you consider yourself: At the right weight?\_\_\_ Overweight?\_\_\_ Underweight?\_\_\_
- 14. Which currently describes your Exercise level? 1-2 days/week\_\_\_ 3-4 days/week\_\_\_ 5-7 days/week\_\_\_ Once or twice a month\_\_\_ What the heck is exercise?\_\_\_
- 15. If male over 40, approx. date of your last prostate exam / PSA blood test? \_\_\_\_\_
- 16. Has there been any change to your family history since last seen by the doctor?
- 17. Has there been any change to your current medications since last seen? Yes\_\_\_ No\_\_\_ If yes, please list: