



FAMILY MEDICAL CENTER

190 Buttercup Creek Blvd.

PO Box 189

Cedar Park, TX 78630-0189

Phone: (512) 336-5824

Fax: (512) 336-5293

Welcome To Our Practice!

Please take a few minutes to answer the following questions so we can better assist you with your healthcare needs.

I. PATIENT INFORMATION

Date: _____ Soc. Sec. # _____ Birthdate: _____

Name: _____
Last First Middle Initial

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Alternate Phone: _____

Sex M F Minor Single Married Long Term Partner Divorced Widowed Separated

Employer: _____ Business Phone: _____

Business Address: _____ Occupation: _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone: _____

II. PRIMARY INSURANCE

Person Responsible for Account: _____
Last First Initial

Relationship to Patient: _____ Birthdate: _____ Soc. Sec. # _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

Responsible Party Employed By: _____ Business Phone: _____

Business Address: _____ Occupation: _____

Insurance Company: _____

Insurance Company Address: _____

Subscriber ID #: _____ Group # _____

III. ADDITIONAL INSURANCE

Insured Name: _____
Last First Initial

Relationship to Patient: _____ Birthdate: _____ Soc. Sec. # _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

Insured Employed By: _____ Business Phone: _____

Insurance Company: _____

Insurance Company Address: _____

Subscriber ID #: _____ Group # _____

AUTHORIZATION AND ACKNOWLEDGEMENT

I / We hereby state that the above information is true and correct to the best of my / our knowledge.
I / We authorize the above named practice to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payors, as required for certain claims filed.

Signature of patient or Guardian **Printed Name** **Date**

I / We authorize direct payment to be made to the above named practice for any and all medical or surgical services rendered. **I understand if any services or charges are not covered by my insurance company, or if my eligibility cannot be verified prior to seeing the physician, I will be responsible for all charges incurred at the time of visit.** By signing below you understand and authorize that you may be billed for any unpaid services.

Signature of patient or Guardian **Printed Name** **Date**



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Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of Family Medical Center'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 this document.

Name of Patient (Please Print)

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

Name of Patient or Personal Representative (Please Print)

Date

Family Medical Center reserves the right to modify the privacy practices outlined in this notice.

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ADULT HEALTH RECORD ADULT MEDICAL HISTORY FORM

Name: _____ Sex: M F Date of Birth: _____ Age: _____
Last First Initial

I. PAST MEDICAL HISTORY

	Yes	No		Yes	No	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid or Glandular	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma & Lung	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver, Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Back/Spine Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Peptic Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head Injury, Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Colon Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	HIV or AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____

II. PAST SURGICAL HISTORY

	Yes	No		Yes	No	
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
Ear Tubes	<input type="checkbox"/>	<input type="checkbox"/>	Hysterectomy (uterus)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/>	Ovaries removed	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroidectomy	<input type="checkbox"/>	<input type="checkbox"/>	Tubal ligation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Vasectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Knee Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gallbladder	<input type="checkbox"/>	<input type="checkbox"/>	Hip Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____

III. MEDICATIONS

Regular Medications (include vitamins, over the counter, birth control, herbal meds)
 (Example: Tagamet, 300 mg, 3 x a day)

	Drug	Drug Strength	Frequency		Drug	Drug Strength	Frequency
1	_____	_____	_____	6	_____	_____	_____
2	_____	_____	_____	7	_____	_____	_____
3	_____	_____	_____	8	_____	_____	_____
4	_____	_____	_____	9	_____	_____	_____
5	_____	_____	_____	10	_____	_____	_____

ALLERGIES TO MEDICATIONS / OTHER: _____

Please describe your current health: _____

Immunizations: _____

GYN (Women only) Age menses began _____ Last menstrual period _____ Pregnancies _____
 Full Term _____ Premature _____ Still Born _____ Abortion/Miscarry _____ Living children _____

IV. SOCIAL HISTORY

Marital Status: Married Single Divorced Widowed
 Do you use tobacco? Yes No Type? _____ How much per day? _____ For how long? _____
 Are you interested in quitting? _____
 Alcohol Yes No How many drinks / week? _____
 Caffeine Yes No How many drinks / day of: coffee tea soda
 Currently sexually active? Yes No New partner in the last year? Yes No
 Highest level of education? _____
 Occupation? _____
 Exposure to toxic chemical, work related injuries or stresses? _____
 Military Service? _____
 Foreign Travel (Where?) _____
 Do you wear seat belts? Always Sometimes Never
 Exercise Schedule? _____
 Major changes, stresses in: Family 1 2 3 4 5 Finances 1 2 3 4 5 Work 1 2 3 4 5
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V. FAMILY HISTORY

	Age	IF LIVING Health	Age	IF DECEASED Cause of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brothers/ Sisters	_____	_____	_____	_____
Children	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Do you have a family history of: (Circle any that apply and explain below, include blood relatives only)

- | | | | |
|--------------------|----------------|--------------------|----------------------|
| Diabetes | Cancer | Heart Disease | High Blood Pressure |
| Peptic Ulcer | Stroke | Heritable Disorder | Rheumatoid Arthritis |
| Epilepsy | Gout | Tuberculosis | Glaucoma |
| Alcohol/Drug Abuse | Kidney Disease | Migraines | Asthma/Lung Disease |
| Colon Disease | Blood Disease | Mental Illness | Sickle Cell Anemia |

Please indicate which family member is/was affected and any details: _____

The above is complete and true to the best of my knowledge. I, the undersigned, voluntarily consent and grant permission to the physician to perform tests, treatments and procedures as indicated for myself or the above named minor for as long as I am a patient of the physician.

 Patient's Signature Date Reviewed by Date



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MEDICAL INFORMATION RELEASE

This release authorizes the Family Medical Center to discuss non-sensitive medical information (such as lab test results, appointment verification, etc) with:

- Patient Only
- Spouse - Specify Name of Spouse: _____
- Parent - Specify Parent Name: _____
- Other (please specify) _____
- May we send you a reminder card? Yes or No (please circle)

TEST RESULTS: ("X" please mark one or all desired)

- ____ We may leave test results at phone # _____
- ____ We may leave a message for you to call Family Medical Center to get your results.

Patient Signature: _____ **Date:** _____
(or Parent / Guardian)

Print Name:

Birth Date:

SS#:



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Patient Name: _____

EMERGENCY CONTACT

Name: _____

Phone: _____

Relationship to Patient: _____

Preferred Pharmacy: (name, location, phone#) _____

OFFICE POLICIES

All co-pays are due before your appointment. All other payments are expected at the time of service unless prior arrangements have been made.

A \$25.00 fee may be assessed for missed appointments. Please call 24 hours prior to your appointment if you are unable to make it.

We are only using Clinical Pathology Laboratories (CPL) for the labs that are sent out. If your insurance company requires that we use another lab, it is your responsibility to let us know before your appointment.

Please let the receptionist know of any changes in your information (such as insurance, address, phone) before your appointment.

WAIVER OF LIABILITY

There may be certain services that are not adequately covered by your insurance company. If the provider feels that this service is medically necessary and your insurance company denies payment, it will be your responsibility to pay for that service.

Signature: _____ Date: _____