



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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CHILD HEALTH RECORD CHILD MEDICAL HISTORY FORM

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

I. ENVIRONMENTAL HISTORY

- City Water Well Water Bottled Water
 Daycare Household Pets Unusual Chemicals or Toxins
 Tobacco Smoke in Home Recent Travel

II. SOCIAL HISTORY

Patients Age: _____ Sex: _____ Grade: _____
Father: Married Divorced Separated Remarried
Father's age: _____ Father's Occupation: _____ Last Grade Completed: _____
Mother: Married Divorced Separated Remarried
Mother's age: _____ Mother's Occupation: _____ Last Grade Completed: _____
Brother's Ages: _____ Sister's Ages: _____
Who is the primary caregiver at home: _____
Has there been any recent family stress or social change? _____

III. CHILD'S MEDICAL HISTORY

Immunizations Current YES NO Record Available YES NO
Please explain any problems of the child in the following areas:
 Asthma Ear Infections Cerebral Palsy
 Bladder/Kidney Infection Diabetes Seizure(s)
 Developmental Delay Learning Disorder Blood Transfusion
 Allergies _____ Hearing/Vision Problems _____
 Hospitalizations/Operations _____
 Injuries _____ Major Illnesses _____
 School Problems _____ Behavioral Problems _____
 Herbal medication or over the counter medications _____
 Alternative healthcare _____
 Chiropractic Acupuncture

List current medications: _____

IV. DISEASES IN FAMILY - Relationship to Patient

Drug Abuse _____ Heart disease before age 50 _____
Alcohol Abuse _____ Hearing Problems _____
Tobacco Abuse _____ High blood pressure _____
Domestic Violence _____ Stroke _____
Epilepsy/Seizures _____ Diabetes _____

continued on next page

Allergies _____ Asthma _____
Birth Defects _____ Cancer _____
Kidney Problems _____ Learning Disorders _____
Mental Illness _____ Any rare or inherited disease _____

V. BIRTH HISTORY (if under the age of 5 years)

Maternal Complications Maternal Substance Abuse
If yes, explain _____

Birth Weight: _____ Birth Length: _____

Any Problems: _____

Patient is Adopted _____ Where was patient born? _____

VI. FINANCIAL ASSESSMENT

Do you currently use any of the following resources? Yes No
If yes, please indicate which ones.

AFDC ECI/Child Team Food Stamps Home Nursing
 CIDC WIC SSI Other _____

Do you have any problems getting your child's medicine? Yes No
Do you have any difficulties getting to your doctor's appointments? Yes No
Do you have a regular social worker or case manager? Yes No

VII. VALUES / BELIEFS ASSESSMENT

Religious preference:

Do you have any beliefs that might affect how we care for your child? (For example, some people refuse blood products or treatments, because it is against their religious / cultural beliefs). Yes No

Explain:

Date: _____ Parent / Guardian Signature: _____



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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 Quest Diagnostics, with onsite lab draws, usually for free, 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: _____