WHITEHOUSE FAMILY MEDICAL

Cheryl D. Layne, Nurse Practitioner 403 State Hwy 110 S. Whitehouse, TX 75791

Phone (903) 202-7002 Fax (903) 202-7003

Patient Name (Last, First) _____ Sex: (Male) (Female) DOB: _____

Social Sec #_____ Email Address:_____

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

Please circle preferred method of communication to confirm appts and to access health information

Mailing address:_____ City:_____State:_____ Zip:_____

Ethnicity: Hisp/Non-Hisp Pref. Language_____Race: White / African American / Amer. Indian / Asian

Next of Kin:_____Relationship:_____ Phone number:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

How did you hear about our office? _____

Insurance Information:

Insurance carrier:_____ Name on card:_____

*If patient is not the cardholder (primary insured) please provide us with the following information. If self, please skip.

Cardholder's name:_____ Cardholder's DOB_____

Cardholder's SSN_____Cardholder's Relationship to patient: Spouse/Guardian/Other

Past Medical History (circle all that apply)

Hypertension	High Cholesterol	Thyroid disease	Diabetes Mellitus
Depression	Stroke	Heart disease	Congestive Heart Failure
Atrial Fibrillation	Menopause	Parkinsonism	Alzheimer's/Dementia
Diverticulitis	Crohns/Colitis	Rheumatoid Arthritis	Osteoarthritis
Incontinence	COPD/Emphysema	Low Testosterone	

Cancer: (type and year)_____

Medication allergies:_____

Preferred Pharmacy:_____

Current Prescriptions: (including dose)

_____ _____

_____ _____

_____ _____

_____ _____

Hospitalizations/Surgeries

_____

_____

Family Medical History (List any health issues for any of your immediate family members listed below)

Mom_____ Dad_____

Siblings_____

Social History

Marital History: Married / Single / Divorced / Separated / Widowed

Alcohol use: Never / Rarely / Occasionally / Daily Type: Beer / Liquor Amount: (# drinks)_____

Do you smoke or use smokeless tobacco? Yes / No How much?_____ How many years total?_____

Advanced Directives

Do you have an Advanced Directive? (Yes) (No). If yes, please provide our office with a copy of your medical record. If you do not we will provide you with information regarding advanced directives and their purpose.

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Patient's Name:_____ DOB:_____ SSN:_____

Address: _____ State:_____ Zip:_____

I authorize _____ to release my medical records to Whitehouse Family Medical.

This authorization applies to: (please circle)

ALL RECORDS ER RECORDS PROGRESS NOTES EKG XRAYS LABS OPERATIVE REPORTS

This purpose for this request is for: (Please circle)

CONTINUATION OF MEDICAL CARE INSURANCE ATTORNEY OTHER_____

Requested period:

ALL DATES: _____ TO _____

I understand that my expressed consent is required to release any health information if I have been tested, diagnosed and/or treated for HIV/AIDS, STD's psychiatric/mental health disorders or drug/alcohol use. You are specifically authorized to release all information related to such a diagnosis, testing or treatment.

_____ _____

Patient's signature Date

Relationship to patient: Self/Parent/Guardian

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE ONE YEAR FROM THE DATE OF MY SIGNATURE UNLESS REVOKED AS SPECIFIED ABOVE. ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT IS PROHIBITED EXCEPT WHEN IMPLICIT FOR THE PURPOSES OF THIS DISCLOSURE.

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Name:_____ **DOB**_____

AUTHORIZATION

I, the undersigned, certify that I (or my dependent) has insurance coverage as listed. I understand that I am financially responsible for all charges, whether paid by insurance or not. I remain responsible for payment of copays, deductibles, non-covered services and any other charges not paid by insurance within 30 days. I hereby authorize Whitehouse Family Medical to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance claims.

X Signature_____ **Date**_____

CONSENT FOR TREATMENT

Having voluntarily presented myself (or my dependent) to Whitehouse Family Medical, I acknowledge recognition of the fact that the evaluation and treatment received, advised or deemed necessary, to be the judgement of the provider.

X Signature_____ **Date**_____

ACKNOWLEDGE OF RECEIPT OF PRIVACY NOTICE (HIPPA)

By signing this form, you acknowledge that you have been offered or given a copy of Whitehouse Family Medical's Privacy Notice, which explains how your health information will be handled in various situations.

☐ I *would* like to receive a copy of the privacy notice.

☐ I have *declined* the opportunity to receive a copy of the privacy notice.

X Signature_____ **Date**_____

ADDITIONAL PERSON(S) AUTHORIZED TO MAKE THE USE OR DISCLOSURE OF MY PHI

We, at Whitehouse Family Medical, value and do everything in our power to protect your privacy. Your medical information will not be given to any individual (including spouses, parents, children, or any other significant others) without your written consent. If you want anyone to have access to your medical records, please list their name, DOB, and relationship below. (Note: Uses and disclosures may be permitted without prior consent in an emergency.)

Name_____ **DOB**_____ **Relationship** _____

Name_____ **DOB**_____ **Relationship** _____

X Signature_____ **Date**_____

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No Show Policy

If you are unable to keep your scheduled appointment, please call the office 24 hours before your appointment to reschedule in order to accommodate another patient. If you no show or cancel without 24 hours notice, we reserve the right to assess a $25 fee.

A total of three no shows may result in a discharge from our office.

Thank you for your cooperation.

_____ _____

Patient's Signature Date