REGISTRATION FORM

Date: ______________________________

Name of Patient: [ ] Date of Birth: [ ]

Address: [ ] Phone: [ ]

City: [ ] State: [ ] Zip Code: [ ]

Emergency Contact: [ ] Relationship: [ ] Phone: [ ]

Health Insurance: [ ] Member ID / GRP ID: [ ]

SSN #: [ ] Email: [ ]

Parent or Legal Guardian: I hereby authorize Pioneer Healthcare Clinic and/or agents to use my general information (address/phone/email) to contact me to facilitate anything related to my medical care.

RELATIONSHIP TO PATIENT:

Person Responsible for Payment: [ ] o Mother o Father o Other

SSN: [ ] o Male o Female Date of Birth: [ ]

Address: [ ] Employer: [ ]

City: [ ] State: [ ] Zip: [ ] Work # [ ]

Authorization to Release Information and Assignment of Benefits

I request that payment of authorized insurance benefits from any applicable insurance carrier be made on my behalf to Pioneer Healthcare Clinic for any services furnished to me by that provider. I authorized medical information needed to determine these benefits payable for the related services to be released to the insurance company and its agents. I understand that even though I have some type of insurance coverage, I am responsible for the payment of services. Please note: It is the policy of this office that any parent who requests treatment for the child is responsible for the payment of all subsequent fees.

Name: ______________________________ Date: ______________________

Signature: ______________________________ Relationship: o Mother o Father o Self

Patient Consent Form

In April of 2003, new federal requirements regarding privacy of information for health care patients took effect. HIPAA, the Health Insurance Portability and Accountability Act requires that all medical providers, insurance companies, and others, put in place controls to ensure that your personal medical information is safe.

Pioneer Healthcare Clinic requires that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital, and insurance company.

By signing this form, consent to our use and disclosure of protected health information about your treatment, payment, and health care operation. You have the right to revoke this consent in writing, except where we have already made disclosures, in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Signature of Patient: ____________ **Date:** ____________

Name of Patient: ____________ **Date of Birth:** ____________

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents, or others to call and request the results of tests and procedures. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your test results released to a family member you must sign this form. Signing this form will only give consent to release laboratory and radiology results to family members indicated below. This consent will not allow Pioneer Healthcare Clinic associates to release any other information to these family members.

You have the right to revoke this consent in writing, except where we have already made disclosures in reliance to your prior consent.

Name: ____________ Relationship to Patient: ____________ Date: ____________

Name: ____________ Relationship to Patient: ____________ Date: ____________

Patient Name: ____________ Patient Signature: ____________ Date: ____________

Authorization to Leave Messages with Household Members/Voicemail

From time to time it is necessary for representatives of Pioneer Healthcare Clinic to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that medical staff would like to discuss lab or procedure results, or to ask a patient to call Pioneer Healthcare Clinic regarding an issue or concern. The purpose of this consent is to leave messages with members of your household or on your voicemail. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance to you prior consent.

Patient Signature: ______________________________ Date: ____________________

TOTAL CARE FAMILY PRACTICE LLC dba PIONEER HEALTHCARE CLINIC

1200 East Davis, Ste. 113 Mesquite, TX 75149 Ph: (972) 295-9090 Fax: (972) 534-0010	2100 Virginia Drive, Ste. D Grand Prairie, TX 75051 Ph: (972) 264-2331 Fax: (972) 264-2333

MEDICATION LIST

Patient Name:______________________________ Date of Birth:______________

Drug Allergies:____

□ NKDA (No Known Drug Allergies

Pharmacy:______________________________ Phone:________________

Pharmacy Address: ______________________________ Fax: ____________

REMEMBER TO UPDATE YOUR MEDICATION & MARK OUT THOSE THAT HAVE BEEN DISCONTINUED

LIST ALL PRESCRIPTION and OVER-THE -COUNTER MEDICATIONS.

Medication Name	Dosage	Times of Day Taken	Special Instructions

____

Print Name Date

____

Signature

HIPPA NOTICE OF PRIVACY 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

This Notice of Privacy Practices describes how we use and disclose your *protected health information* (PHI) to carry out treatment, payment or health operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your *protected health information*.

Uses and Disclosures of Protected Health Information
Your *protected health information* may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment
We will use and disclose your *protected health information* to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your *protected health information* as necessary to a home health agency that provides care of you. For example, your *protected health information* may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment
Your *protected health information* will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay requires that your relevant *protected health information* be disclosed to your health plan to obtain approval for the hospital admission.

Healthcare Operations
We may use or disclose, as needed, your *protected health information* in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you, we may use or disclose your *protected health information*, as necessary, to contact you to remind you of your appointment.

____

Print Patient Name   Date

____

Patient / Parent / Guardian Signature

ADULT HEALTH HISTORY FORM

Date:____________________

Patient Name:______________________________________ **Date of Birth:**________________ **Age:**_________

Present Health Concerns: ____

____

Allergies: □ NONE □ YES (Please Specify)____

Past Medical History: (Please check all that apply)

□ Arthritis □ Cancer □ Depression □ Diabetes □Epilepsy/Seizures □Heart Problems □Heart Surgery

□ High Blood Pressure □ Psychiatric disease □ Stroke □ Thyroid □ None □ Other:____________________

Previous Surgeries & Dates: ____

____

Serious Injury & Date: ____

Do you drink alcohol? □ Yes □ No If yes, how much per week___________________________________

Do you smoke? □ Yes □ No If yes, how many per day ___________________________________

Do you consume caffeine? □ Yes □ No If yes, how many cups per week_____________________________

Do you use recreational drugs? □ Yes □ No If yes, what type & frequency__________________________

Are you on a special diet? ? □ Yes □ No If yes, please describe_______________________________

Date of most recent lab work: ____________ **Have you had a colonoscopy?** □ Yes □ No If yes, when________

<u>For Females:</u> Last Menstrual period _____________ **Mammogram**_______________ **Pap Smear**____________

Health Survey: As you review the following list, please check any problems or conditions that you are experiencing or have experienced. <u>If you do not have any of the problems listed in this section, please check NONE.</u>

<u>General Health</u>: □ Good general health □ Recent weight change □ Loss of appetite □Fatigue □ Fever/Chills

<u>Allergy</u>: □ Drug Allergies □ Food allergies □ Hay fever □ None □ Other__________________

<u>Ears, Nose, Mouth & Throat</u>: □ Difficulty swallowing □ Earache □Loss of hearing/deafness □ Loss of smell/taste

□ Painful chewing □ Ringing in ears □ Sinus infection □ Sores in mouth □ None □ Other__________________

<u>Eyes</u>: □ Blind spots □ Blurred vision □ Double vision □ Glaucoma □ Eye Pain □ Injury □ None

Date:______________

Patient Name:______________________________ **Date of Birth:**____________ **Age:**________

-Continued from page 1-

Gastrointestinal: □ Nausea/Vomiting □ Stomach pain □ Ulcer □ Persistent diarrhea □ Increasing constipation

□ Painful bowel movements □ Blood in stool □ None □ Other______________________________

Genitourinary: □ Kidney stones □ Painful or burning with urination □ Urinary urgency □ Blood in urine

□ Urine retention/incontinence □ Sexual difficulty □ Sexually transmitted diseases (STD) □ None

FEMALE: □ # of pregnancies ______ # of miscarriages _______ □ Irregular Periods □ Vaginal discharge

MALE: □ prostate disease □ Testicle pain If yes, ○ Left ○ Right

Heart & Lungs: □ Chest pain □ High Blood Pressure □ High Cholesterol □ Irregular Heartbeat □ None

Muscles/Bones/Joints: □ Neck / Back pain □ Difficulty walking □ Joint pain / stiffness /swelling □ Muscle pain

Neurological: □ Trouble balancing □ Blackouts / loss of consciousness □ Difficulty speaking □ Difficulty speaking

□ Difficulty walking □ Facial drooping □ Headaches □ Injury to brain/spine □ Dizziness/lightheaded □ Memory loss

□ Confusion □ Migraines □ Mini stroke / stroke □ Numbness/tingling/burning □ Paralysis □ Tremors □ Weakness

□ Other______________________________ Are you? □ Right handed □ Left handed □ Both

Psychiatric: □ Depression □ Anxiety □ Eating disorder □ None □ Other______________________________

Pulmonary: □ Asthma □ Bloody/ chronic cough □ Cancer □ Emphysema □ Pneumonia □ Shortness of breath □None

Skin: □ Rash/itching □ Sun sensitivity □ Hair loss □ Color changes □ None □ Other ____________________

Sleep: □ Snoring □ Sleep walking □ Nightmares Do you sleep well? □ Yes □ No

Do you feel rested when you wake up? □ Yes □ No Do you fall asleep during the day? □ Yes □ No

Is there any family history of: □ Asthma □ Aneurysm □ Brain Tumor □ Cancer, Type____________

□ Diabetes □ Epilepsy/Seizures □ Headaches □ Heart Problems □ High Blood Pressure □ Kidney disease

□ Lung Disease □ Migraine □ Multiple Sclerosis □ Psychiatric Disease □ Stroke □ Thyroid □ None

Comments: ____

____

____