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: [ ] **○ Mother ○ Father ○ Other**

SSN: [ ] **○ Male ○ 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:** **○ Mother ○ Father ○ 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

PEDIATRIC HEALTH HISTORY FORM

Date:____________________

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

Present Health Concerns: ____

____

Allergies: □ NONE □ YES (Please Specify)____

□ Reactions to Medications or Vaccinations____

Pregnancy & Birth Where was your baby born?______________________ Is this child yours by: □ Birth □ Stepchild □ Adoption □ Other______________	**Dental History** Has child been seen by dentist? □ Yes □ No If so, how often? ______ Date of last visit?__________
Please indicate any medical problems during pregnancy ______________________________________ □ None Delivery by: □ Vaginal birth □ Caesarean If Caesarean, why?__________________________ Was your baby premature? □ Yes □ No	**Immunization / Infectious Diseases** **<u>Please provide your child's shot record at your appt.</u>** Has your child had any of the following diseases? □ chickenpox □ measles □ mumps □ rubella □ meningitis
Nutrition & Feeding Is or was your child breastfeeding? □ Yes □ No Has your child had any unusual feeding or dietary issues? □ Yes □ No If yes, please specify:________________ Milk intake now (avg ounces per day)__________ Type: □ whole cow's milk □ Nonfat □ 1% fat □ 2% fat □ Soy milk □ Rice Milk Comments:______________________________	**Exposure/Habits** Any concerns about lead exposure? □ Yes □ No Do any household members smoke? □ Yes □ No TV=hours per day_____ Computer=hours per day______ Video games=hours per day________
Development At what age did your child: Sit alone_________ Walk alone____________Say words_________ Toilet train___________ ***For girls:*** Age at first menstruation cycle:_________ **Family History** Please indicate any deaths of your immediate family members: ______________________________________ ______________________________________	**Past Medical History** Please describe any major medical problems with dates: ______________________________________ ______________________________________ Hospitalizations/Operations with dates: ______________________________________ ______________________________________

PEDIATRIC HEALTH HISTORY FORM (continued)

PIONEER
HEALTHCARE CLINICS

Date:____________________

Patient Name:____________________________________ **Date of Birth:**_______________ **Age:**________

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Please indicate family members with any of the following conditions including (parent, sibling, grandparent, aunt, uncle)

Alcoholism____________________________

High Cholesterol____________________________

Cancer, type: ____________________________

Heart Disease: ____________________________

Stroke: ____________________________

Depression/Suicide:____________________________

Bleeding or clotting disorder:____________________

Genetic Disorders:____________________________

Asthma/COPD:____________________________

Diabetes____________________________

Other:____________________________

Social History

Who lives at home?

Name	Age	Relationship

Are child's parents

□ Married □ Unmarried □ Separated □ Divorced

If divorced or separated, when?____________________

Child care situation: □ parents □ other (specify who and how often)____________________________

____

Concerns about your child

□ Alcohol use □ Tobacco □ Sexual activity

□ Aggressive behavior □ Other:____________________

____

Is violence at home a concern? □ Yes □ No

Are there guns in the home? □ Yes □ No