Brenham Family Practice and Obstetrics PA Patient Registration Information

Please PRINT AND complete ALL sections below!

PATIENT'S PERSONAL INFORMATION

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex:** ☐ Male ☐ Female

Name: _____ (last name) _____ (first name) _____ (initial)

Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____

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

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

PATIENT 'S / RESPONSIBLE PARTY INFORMATION

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Name: _____ (last name) _____ (first name) _____ (initial)

Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____

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

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

PATIENT'S INSURANCE INFORMATION

Please present insurance cards to receptionist.

PRIMARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Name of Insured & Social Security# _____

Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____ Copay: $ _____

SECONDARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Name of insured & Social Security # _____

Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ **Group #:** _____ **Copay:** **$** _____

PATIENT'S REFERRAL INFORMATION

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____

PHARMACY INFORMATION

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip: _____

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

Race: []Decline []Black - African American []White []American Indian []Native Alaskan []Asian []Native Hawiian []Other Pacific Islander []Other Race

Ethnic Group: [] Declined [] Hispanic [] Latino [] Not Hispanic or Latino

Email Address:

Employment

Are you employed? [] yes [] no [] self-employed

Employer: _____

Employer Address:_____

Employer City, State, and Zip:_____

Employer Phone:_____

HR Contact:_____

Occupation:_____

Describe duties:_____

_____

_____

Job stress level: [] low [] moderate []high

Does your job require Lifting? []yes []no

If your job requires lifting is it? [] light [] moderate [] heavy

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Newborn Information

Time of Birth:_____

Birth Hospital:_____

Was birth a: [] Full-Term Birth (after 37 weeks) ([] Premature Birth (less than 37 weeks)

Was birth by: [] Vaginal [] C-Section

Gestational Age at Birth: _____ Weeks _____Days

(Flip to Next Page)

Date:

601 MEDICAL PARKWAY, ST D
BRENHAM, TEXAS 77833

BRENHAM FAMILY PRACTICE AND OBSTETRICS

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

FINANCIAL AGREEMENT

I understand my insurance is a contract between myself and my insurance company and that Brenham Family Practice and Obstetrics will bill my insurance as a courtesy to me. I understand that I am responsible for deductibles, co-pays, non-covered services, coinsurance and items considered "not medically necessary" by my insurance company. I agree to pay copayments, deductibles, and/or coinsurance at the time of service. If a referral and/or preauthorization is required by my insurance company, I will assist Brenham Family Practice and Obstetrics in obtaining the referral and/or preauthorization. Brenham Family Practice and Obstetrics may verify benefits on my behalf; however the final determination will be made by my insurance company at the time of payment. I understand that I am ultimately responsible for any balance on my account.

_____(initial) **COLLECTION FEES AND RETURNED CHECKS**

I understand a collection fee will be added to my account balance if placed with a collection agency to cover the cost charged by the collection agency. This could be approximately 35% to 50% of the amount owed. I agree to pay this fee associated with the collection of any overdue balance. I understand a $40.00 service charge will be charged for all return checks.

_____(initial) **ASSIGNMENT OF BENEFITS**

I hereby assign to Brenham Family Practice and Obstetrics such insurance benefits to which are entitled under my insurance plan(s).

_____(initial) **RELEASE OF INFORMATION**

I hereby allow Brenham Family Practice and Obstetrics to furnish any information pertaining to my medical treatment to my insurance carrier, attorney, or other providers of service necessary to obtain payment of service and provide additional care.

_____(initial) **CONSENT FOR TREATMENT**

I hereby authorize Brenham Family Practice and Obstetrics to examine, treat, and perform diagnostic test and office procedures that the provider deems necessary.

_____(initial) **NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT OF RECEIPT**

By signing below, I am stating that I have read and received a copy of the Notice of Privacy Practices for Brenham Family Practice and Obstetrics

I have read and agree to the Financial Agreement, Assignment of Benefits, Release of Information , and Consent For Treatment as listed above. My signature below also indicates that I have reviewed a copy of the Brenham Family Practice and Obstetrics Notice of Privacy Practices and I have indicated any restrictions on my protected health information above. Everything I have filled out is true to the best of my knowledge.

Scanned signatures suffice as originals.

_____

Patient or Responsible Party **(Sign and print)** Date

_____

Guardian of minor **(Sign and print)** Date

HIPAA PRIVACY NOTIFICATION FORM

Last Name First Name Middle Initial

Primary Phone: _____ Date of Birth: _____

If we are unable to reach you by at your home phone we will try one of the checked boxes below. If we are unsuccessful, we will then mail you a letter as a final attempt to inform your of results.

It is often difficult to reach patients and our staff may not always be readily available when patients respond to 'call back' message left on answering machines or with a family member. To facilitate contacting you in a timely manner and to comply with federal HIPAA regulations, please complete the following. Please check the appropriate choice or choices for you:

_____ You may only speak to me personally. If a staff member is unable to come to the phone, I will leave a number and a time where and when I can be reached later that day or the next day.

_____ You may call me at work. Work Phone: _____ Ext. _____

_____ You may call my cell phone. Cell Phone: _____

_____ You may leave a message on my answering machine or voicemail regarding those items checked below at:

_____ Home _____ Work _____ Cell

_____ You may leave a message regarding those items checked below with the following family members:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ Other Request: _____

_____

	BLOOD WORK		**REFERRALS**		**APPOINTMENTS**
	PAP SMEAR		**MAMMOGRAM**		**CULTURES**
	XRAYS / CT / MRI		**MEDICAL RECORDS**		**XRAYS**
	ALL OF THE ABOVE and/or any other test performed				

Results regarding sexually transmitted diseases, whether positive or negative, will ONLY be given to the Patient.

I understand that Brenham Family Practice and Obstetrics will make reasonable efforts to accommodate this request for as long as I am a patient; but I can request a change at any time. I further understand that in some emergency situations, my protected health information may be released.

_____ _____

Patient / Parent / Guardian Signature *Date*

BRENHAM FAMILY PRACTICE AND OBSTETRICS
HIPPA PRIVACY AND DISCLOSURE POLICY NOTICE
Privacy and Disclosure Authorization Policy:
For Storage and Disclosure of Confidential Information and Records

1. This Notice describes how your health information, including therapy records, may and may not be used and disclosed to others, and how you may gain access to this health information. Please review the information in this Notice carefully.
2. **The Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)** provides strict guidelines about the maintenance, use, storage, and disclosure of client medical information called Protected Health Information (PHI). HIPAA also requires that those who receive health services be given written statements of the privacy policies of the health providers. In addition to HIPAA guidelines, there are many other federal, state, and professional guidelines and ethical standards that inform our policies and practices at BRENHAM FAMILY PRACTICE AND OBSTETRICS PA. While we are required to keep records of services provided, we are also required to safeguard this information. BRENHAM FAMILY PRACTICE AND OBSTETRICS PA staff will make every effort to safeguard your privacy and your rights.
3. You as a health services consumer have a right to know how information about you and about services you receive may be used. You also have rights to ask for limits on the disclosures made on your behalf, and to have appropriate access to your records for review and release.
4. The **Policies and Practices of Health In Balance Physical Therapy, LLC**, regarding PHI privacy and disclosure are contained in the Notice. The purposes for the maintaining and disclosing of client records relates to providing services, as requested by our clients, and generally are involved in treatment, payment, and other health care operations, such as those required by government agencies or in emergency situations.
5. Based on legal regulations and ethical guidelines, BRENHAM FAMILY PRACTICE AND OBSTETRICS PA will only disclose information about you to persons or organizations outside of our clinic in a limited number of situations:
a. With your written and specific permission (consent).
b. If required to do so by certain specific court orders, subpoenas, or Workers' Compensation inquires.
c. In cases where laws require reporting for protection, such as significant danger to self or others, child, or elder abuse or neglect.
d. When confidential audits are lawfully conducted by governmental or insurance oversight agencies (such as for clinic licensing).
e. When an emergency required immediate communication with appropriate persons in order to secure appropriate help or treatment: in these situations, the minimum disclosure necessary to secure services will be provided.
f. In order to bill for services provided by BRENHAM FAMILY PRACTICE AND OBSTETRICS PA. Payers are typically insurance companies or other responsible parties. Billing services and insurance companies are also bound by HIPAA and other governmental agencies.
g. When a client in treatment is transferred or completes treatment, follow-up contact is required by statute.
h. Note: when the client is a minor, privacy rights belong to the parents, except in certain situation. Please discuss age-related rights with your doctor.

6. Based on legal regulations and ethical guidelines, BRENHAM FAMILY PRACTICE AND OBSTETRICS PA doctors/nurses/staff will use or disclose your PHI within the clinic:
a. To provide services to you, including: Consultation and coordination of services among personnel and professional consultants (as appropriate), in order to aid in diagnosis, assessment and treatment planning, and in facilitation of ongoing treatment, with professional supervision as required by law.
b. To maintain business records, as required legally and ethically. We maintain client records in file folders, kept in locked file cabinets, and are destroyed by

shredding after they have been held as required by law (and not less than seven years after client discharge). BRENHAM FAMILY PRACTICE AND OBSTETRICS PA also maintains records on computer, respecting legal and ethical privacy guidelines.
c. To share and discuss with you your PHI as contained in clinic records, with a prior written request; also, you may update or correct (add to) your PHI as needed. State law does provide some restrictions on these rights (when judged to be in your best interest). In addition, you may request a listing of non-routine disclosures made of your PHI records. You may also choose how we communicate with you, as via an alternative address or phone number.
d. Examples of other situations that might involve disclosure: Consultation regarding emergency planning, defense of lawsuits, or processing of grievances, or you bringing a friend with you during therapy sessions.
7. **Consent:** Your signature on your new patient demographics, indicates that you are aware of the collection and storage of treatment, payment and other health care information, and that you consent to its use in the course of services provision, billing and collection procedures, and within BRENHAM FAMILY PRACTICE AND OBSTETRICS PA , as discussed above. This form has no expiration date, unless amended or
revoked. You may revoke this consent with written notice at any time, except to the extent that it has already been acted upon.
You may restrict the released information and its use, as indicated on the appropriate form, or restrict its use within BRENHAM FAMILY PRACTICE AND OBSTETRICS PA, but doing so may legally or ethically compromise our ability to provide you with medical services. We may therefore determine that we are unable to provide those services in good faith.
8. There is a separate form for consent to release/exchange information with your insurance company or other third party payer.
9. Other relevant information: **Fees for Copying Records:** A uniform and reasonable fee may be charged for copying records. That fee may be reduced or waived in accordance with BRENHAM FAMILY PRACTICE AND OBSTETRICS PA policy. Health In Balance Physical Therapy, LLC will ordinarily have 2 weeks to respond to a request to copy records. **Transportation of Records:** Whenever records must be transported out of the office, great care will be taken to protect client privacy. **Electronic Transmissions:** E-mail and Internet communications may be used within BRENHAM FAMILY PRACTICE AND OBSTETRICS PA. In those rare instances, BRENHAM FAMILY PRACTICE AND OBSTETRICS PA staff will take care to limit identifying information within the messages, and to make sure the recipient is authorized to receive the information. **Future Changes:** BRENHAM FAMILY PRACTICE AND OBSTETRICS PA will revise and update this information and form as needed, and in compliance with the law.

Complaints: has BRENHAM FAMILY PRACTICE AND OBSTETRICS PA a Grievance Policy posted in the office: clients may ask any BRENHAM FAMILY PRACTICE AND OBSTETRICS PA staff for a copy of the policy. You may also contact any BRENHAM FAMILY PRACTICE AND OBSTETRICS PA for further information about our privacy and disclosure policies, or about HIPAA questions. Privacy concerns may be addressed to the Secretary of the U.S. Department of Health and Human Services. Information and assistance may be found through the HHS Office for Civil Rights (website:httc.www.hhs.gov/ocr/hipaa).