Conroe Family PHYSICIANS
Together Achieving Better Health

690 S. Loop 336 W #140
Conroe, TX 77304
T 936 523 7041
F 936 523 7042

Today's Date _____

Patient's Name (Mr./ Mrs./Ms.)_____

Parents/Guardians (if minor)_____

Mailing Address_____

City _____ State _____ Zip _____ Primary Phone _____

_____Work/Cell_____Email _____

DOB_____Sex: M / F/ Other DL#_____SS#_____-_____-_____

Marital Status_____Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Declined

Race: ☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander ☐ Caucasian ☐ Hispanic ☐ African-American

Other Employer_____Occupation _____

Primary Care Physician _____

How did you find our office?_____Name if referred by a friend or family_____

Emergency Contact Information:

Name_____Relationship_____Phone_____

Responsible Party
Who is responsible for the account? (Mr. /Mrs. /Ms.) _____
Address/City/State/Zip _____
Relationship to patient_____SS#_____-_____-_____DOB _____
Employer_____Occupation_____
Primary Phone_____Work/Cell_____Other_____

Primary Insurance
Insurance Co._____
Policy # _____
Group # _____
Policy Holder's DOB _____
Relationship to Pt _____

Secondary Insurance
Insurance Co. _____
Policy #_____
Group # _____
Policy Holder's DOB _____
Relationship to Pt _____

Financial Policy

Any out-of-pocket expense for the patient such as co-pays, deductibles, or co-insurances must be paid at the time of the clinic visit including services that are not covered under the patient's benefit plan.

Authorization and Release (please sign below)

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payments of benefits be made to Conroe Family Physicians. I acknowledge that I am financially responsible for payment of services not covered by insurance.

Signature:_____Date: _____

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Office and Financial Policies

Welcome and thank you for choosing Conroe Family Physicians for your medical care. We are committed to providing you with the highest quality medical care in an efficient and cost-effective manner. We hope that by providing our patients with our policies in advance, we can prevent any misunderstanding or frustration at the time of your visit.

Initials:_____Insurance: The patient is responsible for knowing their insurance benefits including their deductible and out- of-pocket expenses. Copay, deductibles and patient's financial portion including any balance will be collected at the time of service. You may be asked to reschedule your appointment for non-payment. We will gladly file your insurance claim on your behalf. We will not be involved in disputes between you and your insurance company regarding coverage and/or policy benefits. You are responsible for the timely payment on your account.

Initials:_____Cancellations/No Show Fee: Please call our office at least 24 hours in advance if you are unable to keep a scheduled appointment. You will be charged a No Show Fee of $50 for failure to keep the appointment as scheduled or a $30 fee if the appointment is cancelled with less than 24 hours' notice.

Initials:_____PCP Assignment: Patients with an HMO policy need to choose one of our doctors as their PCP to be seen at Conroe Family Physicians. Please note that when changing your PCP, it may not get updated within 24 hours. You may be asked to reschedule if insurance still shows another physician as a PCP.

Initials:_____Patient Balances: Please be prepared to pay for the current visit as well as any past balances on your account. Copay, deductible, out-of-pocket expenses and non-covered services must be paid at the time of service. For your convenience we take cash, check and credit cards.

Initials:_____Late Arrivals: We do our best to reduce patient wait time but when a patient arrives late, it is impossible to stay on schedule. If you arrive 10 minutes or more after your scheduled appointment time, you will need to reschedule your appointment.

Initials:_____ Dishonored Checks: A $30 Return Check Fee will be assessed on all dishonored checks. If you have 2 dishonored checks on file, check payment will no longer be a payment option for you, but we will gladly accept cash or credit card payments at your future visits.

Initials:_____Collections: You will be receiving at least 3 statements from our office for balances owed before it gets referred to collections. Please make payment arrangements, if necessary, to keep your account current. If your address changes, it is your responsibility to inform Conroe Family Physicians to update our records. Your account will be turned over to collections when your statement returned due to a bad address. When your account is already in collections, you may not be seen until the account is paid in full at the collection agency.

Initials:_____Prescriptions: It is the patient's responsibility to make an appointment for prescription refills prior to running out of chronic medications. All patients must be evaluated before refilling any chronic medications.

Initials:_____Walk-in Appointments: A limited number of walk-in appointments are available as the schedule allows for one acute issue or medication refill only. Therefore, please be advised that walk-in appointments may experience longer wait times or may be accommodated only after all scheduled appointments.

I have read understand and agree to the above office and Financial/Office policies. I hereby attest that I have given and agree to provide current demographics and insurance information and authorize release of information necessary for insurance filing by signing this statement.

Patient Name:_____Date:_____

Patient Name: _____

DOB: _____

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PATIENT HEALTH HISTORY

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____

Other concerns: _____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1. _____	_____
2. _____	_____
3. _____	_____

PREFERRED PHARMACY

Name: _____ Address: _____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over the counter drugs, such as vitamins and inhalers.

DRUG NAME	DOSE/STRENGTH	FREQUENCY TAKEN
1. _____		_____
2. _____		_____
3. _____		_____
4. _____		_____
5. _____		_____
6. _____		_____
7. _____		_____
8. _____		_____

IMMUNIZATION HISTORY

Immunizations and most recent date:

- ☐ Varicella (Chickenpox) Date: _____
- ☐ Flu Shot Date: _____
- ☐ Gardasil (HPV) Date: _____
- ☐ Hepatitis A Date: _____
- ☐ Hepatitis
- ☐ Zostavax (Shingles) Date: _____
- ☐ Meningococcus Date: _____
- ☐ MMR (Measles, Mumps, Rubella) Date: _____
- ☐ Pneumovax (Pneumonia) Date: _____
- ☐ Tdap (tetanus/diptheria/pertussis) Date: _____
- ☐ Tetanus Date: _____

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REVIEW OF SYSTEMS

Patient Name: _____

DOB: _____

Please check all that apply:

Allergic/Immunologic
- ☐ Frequent Sneezing
- ☐ Hives
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure
- ☐ Post Nasal drip
- ☐ Nasal Congestion

Constitutional
- ☐ Fatigue
- ☐ Fever/Chills
- ☐ Night Sweats
- ☐ Weight Gain (_____lbs)
- ☐ Weight Loss (_____lbs)

Eyes
- ☐ Dry Eyes
- ☐ Watery eyes
- ☐ Irritation
- ☐ Vision Loss/Change

Date of Last Exam: _____

Ears/Nose/Throat
- ☐ Bleeding Gums
- ☐ Difficulty Hearing
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Ear Pain
- ☐ Frequent Infections
- ☐ Frequent Nosebleeds
- ☐ Hoarseness
- ☐ Mouth Breathing
- ☐ Mouth Ulcers
- ☐ Nose/Sinus Problems
- ☐ Ringing in Ears

Respiratory
- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Apneic Episodes
- ☐ Snoring
- ☐ Wheezing

Cardiovascular
- ☐ Arm Pain on Exertion
- ☐ Chest Pain on Exertion
- ☐ Chest Heaviness/Pressure on Exertion
- ☐ Exercise Intolerance
- ☐ Irregular Heart Beats (Palpitations)
- ☐ Known Heart Murmur
- ☐ Light Headed on Standing
- ☐ Shortness of Breath When Lying Down
- ☐ Shortness of Breath When Walking
- ☐ Swelling (edema)

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Black or Tarry Stool
- ☐ Blood in Stool
- ☐ Change in Appetite
- ☐ Constipation
- ☐ Frequent Indigestion/Reflux
- ☐ Hemorrhoids
- ☐ Trouble Swallowing
- ☐ Vomiting

Genitourinary
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Erectile Dysfunction
- ☐ Incomplete Emptying
- ☐ Increased Urinary Frequency
- ☐ Urinary Incontinence

Musculoskeletal
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Aches
- ☐ Muscle Weakness

Neurological
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches/Migraines
- ☐ Memory Loss
- ☐ Numbness
- ☐ Restless Legs
- ☐ Seizures
- ☐ Tremor
- ☐ Weakness

Psychiatric
- ☐ Alcohol Overuse/Abuse
- ☐ Anxiety/Stress
- ☐ Depression
- ☐ Symptoms of Mania
- ☐ Sleep Problems
- ☐ Suicidal Thoughts

Integumentary (Skin)
- ☐ Changes in Moles
- ☐ Dry Skin
- ☐ Eczema
- ☐ Growths/Lesions
- ☐ Hair loss
- ☐ Itching
- ☐ Jaundice (Yellow Skin/Eyes)
- ☐ Rash

Endocrine
- ☐ Fatigue
- ☐ Increased Thirst
- ☐ Increased Hunger
- ☐ Increased Urination
- ☐ Heat/Cold intolerance
- ☐ Loss of Libido

Hematologic/Lymphatic
- ☐ Easy Bruising/Bleeding
- ☐ Swollen Glands/Lymph Nodes

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PAST MEDICAL HISTORY

Patient Name: _____

DOB: _____

Please check all that apply:

- ☐ Autoimmune Disorders
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Bleeding Disorder
- ☐ Blood Clots (DVT, PE)
- ☐ Blood transfusion
  Reason: _____
- ☐ Cancer _____
- ☐ COPD/Emphysema
- ☐ Chronic Pain
- ☐ Chemical dependency/Alcoholism
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes D Insulin Dependent
- ☐ Dialysis
- ☐ Eating Disorder
- ☐ Epilepsy/Seizure disorder
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hiatal Hernia or Reflux Disease
- ☐ HIV or AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leg/Foot Ulcers
- ☐ Liver Disease
- ☐ Lower extremity edema
- ☐ Migraines
- ☐ Pacemaker
- ☐ Peripheral Vascular disease
- ☐ Pneumonia
- ☐ Prostate Disease
- ☐ Osteoporosis/Osteopenia
- ☐ Sickle Cell Disease
- ☐ Sickle Cell Trait
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Other _____

PAST SURGICAL HISTORY

	SURGERY	REASON	YEAR	HOSPITAL
1.				
2.				
3.				
4.				
5.				

SOCIAL HISTORY

Occupation

_____

Education ☐ Less than 8th grade ☐ High school ☐ some college ☐ Bachelor Degree ☐ Advanced Degree

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic partner

Exercise Level ☐ None (No exercise)
☐ 1-2 days per week ☐ 3-4 days per week ☐ 5 + days per week

Caffeine ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
# of cups/cans per day?

Alcohol
Do you drink alcohol?
☐ Yes ☐ No
If so, how often?
☐ Occasionally
☐ < 3 times a week
☐ > 3 times a week
How many drinks per week? ____

Tobacco
Do you use tobacco?
☐ Yes ☐ No
If not currently, did you ever use tobacco? ☐ Yes ☐ No
☐ Cigarettes pks./day
☐ Chew____/day
☐ Cigars____/day
☐ # of years _____
Or year quit _____

Drugs Do you currently use recreational or street drugs?
☐ Yes ☐ No
If yes, list: _____
_____

FAMILY HEALTH HISTORY

Patient Name: _____

DOB: _____

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RELATION	ALIVE?	AGE	
Grandmother (maternal)	Y/N	_____	☐ Alcoholism ☐ Anemia/blood disorder ☐ Autoimmune disease ☐ Cancer_____ ☐ Depression/mental illness ☐ Diabetes disease ☐ Genetic disease_____ ☐ Heart disease ☐ Hypertension ☐ Kidney disease ☐ Obesity ☐ Osteoporosis ☐ Stroke
Grandfather (maternal)	Y/N	_____	☐ Alcoholism ☐ Anemia/blood disorder ☐ Autoimmune disease ☐ Cancer_____ ☐ Depression/mental illness ☐ Diabetes disease ☐ Genetic disease_____ ☐ Heart disease ☐ Hypertension ☐ Kidney disease ☐ Obesity ☐ Osteoporosis ☐ Stroke
Grandmother (paternal)	Y/N	_____	☐ Alcoholism ☐ Anemia/blood disorder ☐ Autoimmune disease ☐ Cancer_____ ☐ Depression/mental illness ☐ Diabetes disease ☐ Genetic disease_____ ☐ Heart disease ☐ Hypertension ☐ Kidney disease ☐ Obesity ☐ Osteoporosis ☐ Stroke
Grandfather (paternal)	Y/N	_____	☐ Alcoholism ☐ Anemia/blood disorder ☐ Autoimmune disease ☐ Cancer_____ ☐ Depression/mental illness ☐ Diabetes disease ☐ Genetic disease_____ ☐ Heart disease ☐ Hypertension ☐ Kidney disease ☐ Obesity ☐ Osteoporosis ☐ Stroke
Father	Y/N	_____	☐ Alcoholism ☐ Anemia/blood disorder ☐ Autoimmune disease ☐ Cancer_____ ☐ Depression/mental illness ☐ Diabetes disease ☐ Genetic disease_____ ☐ Heart disease ☐ Hypertension ☐ Kidney disease ☐ Obesity ☐ Osteoporosis ☐ Stroke
Mother	Y/N	_____	☐ Alcoholism ☐ Anemia/blood disorder ☐ Autoimmune disease ☐ Cancer_____ ☐ Depression/mental illness ☐ Diabetes disease ☐ Genetic disease_____ ☐ Heart disease ☐ Hypertension ☐ Kidney disease ☐ Obesity ☐ Osteoporosis ☐ Stroke
Brother/Sister	Y/N	_____	☐ Alcoholism ☐ Anemia/blood disorder ☐ Autoimmune disease ☐ Cancer_____ ☐ Depression/mental illness ☐ Diabetes disease ☐ Genetic disease_____ ☐ Heart disease ☐ Hypertension ☐ Kidney disease ☐ Obesity ☐ Osteoporosis ☐ Stroke
Brother/Sister	Y/N	_____	☐ Alcoholism ☐ Anemia/blood disorder ☐ Autoimmune disease ☐ Cancer_____ ☐ Depression/mental illness ☐ Diabetes disease ☐ Genetic disease_____ ☐ Heart disease ☐ Hypertension ☐ Kidney disease ☐ Obesity ☐ Osteoporosis ☐ Stroke
Other: _____	Y/N	_____	☐ Alcoholism ☐ Anemia/blood disorder ☐ Autoimmune disease ☐ Cancer_____ ☐ Depression/mental illness ☐ Diabetes disease ☐ Genetic disease_____ ☐ Heart disease ☐ Hypertension ☐ Kidney disease ☐ Obesity ☐ Osteoporosis ☐ Stroke

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

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Patient Name: _____

DOB: _____

Last PAP Smear Date:_____ ☐ Abnormal _____
Last Mammogram Date:_____ ☐ Abnormal _____
Age of first menstrual period: _____
Date of last menstrual period or age of menopause: _____
Number of pregnancies:_____Births:_____Miscarriages: _____
Abortions:_____
Cesarean Section: If yes, then number: _____

☐ Bleeding between periods
☐ Heavy periods
☐ Extreme menstrual pain
☐ Vaginal itching/burning
☐ Vaginal discharge
☐ Frequent urination at night
☐ Hot flashes
☐ Breast lump
☐ Nipple discharge
☐ Painful intercourse
☐ Sexually active

Current sexual partner is ☐ Female ☐ Male
Do you use condoms? ☐ Yes ☐ No
Other Birth control method used: _____
Interested in being screened for STD's ☐ Yes ☐ No

Please add any other information about your health that you would like your provider to know here:

_____

_____

_____

_____ _____

Parent, Guardian, or Caregiver Signature Date

Health Insurance Portability and Accountability Act (HIPAA)

A. Inspection and copies of protected health information – you may inspect and / or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that a request for copies be made in writing and we ask that request for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document. We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies. We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons: The information is psychotherapy notes; the information reveals the identity of a person who provided information under a promise of confidentiality; the information is subject to the Clinical Laboratory Improvements Amendments of 1988; the information has been compiled in anticipation of litigation. We can refuse to provide access to or copies of some information for other reasons, provided that we arrange for review of our decision to deny access. Texas law requires us to be ready to provide copies or a narrative report within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing. HIPAA permits us to charge a reasonable cost-based-fee.

B. Amendments of Medical Information – you may request an amendment of your medical information in the designated records set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons: The information was not created by this practice or physicians in this practice; the information is not part of the designated records set; the information is not available for inspection because of an appropriate denial; the information is accurate and complete. Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical records. If we refuse to allow an amendment to be made and tell others that we now have the correct information.

C. Accounting of Certain Disclosures – HIPAA privacy regulations permit you to request,and us to provide, and accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by our or your representative. Please submit any request for an accounting to the person at the end of this document. You first accounting of disclosures (within a 12-month period) will be free. For additional request within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you, and you may choose to withdraw or modify your request before any costs are incurred.

D. Appointment Reminders, Treatment Alternatives, and Other Benefits – We may contact you by (telephone, mail or both) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

E. Complaints – If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. We will not retaliate against you for filling a complaint with us or the government.

F. Our Promise to you – We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of your privacy practices with respect to protected health information, and to abide by the terms of notice of privacy practices in effect.

G. Questions and Contact Person for Requests - If you have any question or want to make a request pursuant to rights described above, please contact our office at 936 523 7041.

I acknowledge that I have been given an opportunity to review Conroe Family Physicians Notice of Privacy Policies and have been provided a copy if I desire one.

_____	_____	_____
Signature of Patient or Legal Representative	Relationship to Patient	Date

Your Birthday AND address will be used to verify identity on your behalf.

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Health Disclosure Consent Form

I,_____, DOB_____, will allow Conroe Family Physicians, to disclose information to the following person(s) about my health. I have also reviewed and acknowledged the Notice of Privacy Practices.

I will allow disclosure to the following person(s):

Name:	Relationship:
1._____	_____
2. ._____	_____
3._____	_____
4._____	_____
5._____	_____

Can we leave a message to your voicemail? ☐Yes ☐No

If Yes, at what number? _____ (I understand that I am the only person who can receive this message for privacy and security purposes)

Leave message only for the following:

_____Appointment Reminder

_____Normal Lab Results

_____Response to Your Voicemail

_____Referral/Testing/ Procedure Scheduling

_____ _____

Signature of Patient or Personal Representative Date