PATIENT REGISTRATION FORM

Printed Name of Patient (first, middle, last name)		Birthdate (mm/dd/yyyy)
Address (Street Address, City, State, Zip Code)		
Phone Number	E-mail	
Marital Status		Gender

EMERGENCY CONTACT INFORMATION

Printed Name of Emergency Contact (first, middle, last name)
Relationship to Patient (Parent, Child, Spouse, Other- Please Specify)
Phone Number

HIPAA RELEASE INFORMATION

Printed Name of Emergency Contact (first, middle, last name)
Relationship to Patient (Parent, Child, Spouse, Other- Please Specify)
Phone Number

Printed Name of Emergency Contact (first, middle, last name)
Relationship to Patient (Parent, Child, Spouse, Other- Please Specify)
Phone Number

INSURANCE AND FINANCIAL INFORMATION

Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)

PRIMARY INSURANCE

Carrier	
Policy Name	Group Number or Name
Is the Patient the Primary Insured? (Yes or No) If No, please give the following information of the primary insured	
Printed Name of Primary Insured (first, middle, last name)	Birthdate (mm/dd/yyyy)
Social Security Number	Relationship to the Patient (Parent, Child, Spouse, Other- Please Specify)

SECONDARY INSURANCE

Carrier	
Policy Name	Group Number or Name
Is the Patient the Primary Insured? (Yes or No) If No, please give the following information of the primary insured	
Printed Name of Primary Insured (first, middle, last name)	Birthdate (mm/dd/yyyy)
Social Security Number	Relationship to the Patient (Parent, Child, Spouse, Other- Please Specify)

GUARANTOR INFORMATION

Printed Name of Guarantor (first, middle, last name)	Relationship to the Patient (Parent, Child, Spouse, Other- Please Specify)
Address (Street Address, City, State, Zip Code)	
Phone Number	E-mail
Employer Name and Address	Work Phone Number

FINANCIAL RESPONSIBILITY AGREEMENT

Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)

I understand and agree to pay the co-pay or patient due balances before being seen by the physician.

Initial	I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, preventative exam, physical, lab testing, x-ray, EKG and any other screening service or diagnostic testing ordered by the physician or the physicians' staff.
Initial	I understand and agree it is my responsibility and not the responsibility of the physician or clinic to know if my insurance will pay for my medical service or visit. For preventative or physical exams, lab testing, x-ray, EKG, or any other screening service or diagnostic testing ordered by the physician or the physicians' staff.
Initial	I understand and agree is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out of network amount, usual and customary limit, or any other type of benefit limitation for the services I receive and I agree to make full payment.
Initial	I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.
Initial	I understand and agree it is my responsibility to know if my PCP choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.
Initial	I understand that I will be receiving a bill from BEST WAY CLINIC OF BURLESON for any and all balances due to be billed on behalf of BEST WAY CLINIC OF BURLESON.

Printed Name of Patient or Personal Representative (first, middle, last name)	
Signature of Patient or Personal Representative	Date Signed

AUTHORIZATION TO RELEASE MEDICAL RECORDS

(This authorization complies with HIPAA)

Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)
Address (Street Address, City, State, Zip Code)	
Phone Number	E-mail

Printed Name of Guardian or Legal Representative (first, middle, last name)	
Address (Street Address, City, State, Zip Code)	
Phone Number	E-mail

I hereby authorize any health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, and family member to release all health information about me.

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, or family member to release all health information about me:

Person/Organization to Release Information		
Street Address		
City	State	Zip Code
Phone Number	Fax Number	

The following person/organization is hereby authorized to receive my entire medical record, treatment record and diagnostic record to the following person or organization:

Person/Organization to Receive Information		
Street Address		
City	State	Zip Code
Phone Number	Fax Number	

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

The following health information that relates to service beginning from _____ to _____, may be released:

- Entire Medical Record including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers.
- Patient Histories
- Office Notes (except psychotherapy notes)
- Test Results
- Radiology Studies
- Films
- Referrals
- Consults
- Billing Records
- Insurance Records
- Records Sent by Other Health Care Providers

I further understand that my medical record may include one or more of the following:

- Treatment of communicable diseases, including sexually transmitted diseases, venereal diseases, tuberculosis, or hepatitis
- HIV-Related Treatment
- Mental Health Information or Psychological Conditions
- Alcohol or Substance Abuse Treatment
- Genetic Testing

The above person/organization, its employees, representatives and any other persons performing services for them or on their behalf, may need to obtain, use or disclose any and all information about my physical and mental health, including but not limited to, services for preventative, diagnostic and therapeutic care, tests, counseling, and medical prescriptions for the purpose of:

□ Change of Doctor

□ Individual Request

□ Specialist Referral

□ Workers Compensation

□ Insurance Purposes

□ Continued Treatment

□ Legal Investigation

□ Other: _____

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

This authorization is valid for 24 months following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Signature of Patient or Personal Representative:	Date Signed:	Description of Personal Representative's Authority:

PATIENT HEALTH QUESTIONNAIRE

Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)

Please list the names of providers you have seen in the past

Name	Specialty	Address	Phone Number

Please list preferred pharmacy

Name	Address	Phone Number

Please list your current medications

Name	Strength	Frequency	Quantity

Please list any allergies or intolerances

Agent / Substance	Reaction

Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)

PAST MEDICAL HISTORY (please use an "X" to indicate if you now have or ever had the following medical conditions)

ADHD	Allergies	Diabetes	Heart problems	HIV/AIDS
Anemia	COPD	Epilepsy (seizures)	High blood pressure	Kidney disease
Angina	Cancer (type)	Heart murmur	Hypothyroidism	Stroke
Asthma	Cataracts	Hepatitis (type)	High cholesterol	Tuberculosis
Other (please specify)				

SURGICAL HISTORY (please list any past surgeries)

Date (mm/yyyy)	Surgery

HOSPITALIZATIONS (please list any past hospital stays)

Date (mm/yyyy)	Reason

FAMILY HISTORY (please use an "X" to indicate if there is a family history of the following medical conditions)

Member	Status (alive, deceased, unknown)	Diabetes	Hyper-tension	Heart Disease	Mental Illness	Cancer (type)	Other (please specify)	Unknown
Mother								
Father								
Siblings								
Maternal Grand Mother								
Maternal Grand Father								
Paternal Grand Mother								
Paternal Grand Father								
Daughter(s)								
Son(s)								
Maternal aunt								
Maternal uncle								
Paternal aunt								
Paternal uncle								

BEST WAY
CLINIC OF BURLESON

Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)

TOBACCO HISTORY (please use an "X" to indicate your answer)

Do you currently use tobacco products?

No	Yes

Are you a

current smoker	former smoker	nonsmoker	current every day smoker	current some day smoker
Smoker current status unknown	unknown if ever smoked	heavy tobacco smoker	light tobacco smoker	

Do you use tobacco in other forms?

No	Yes

If current smoker, how often do you smoke cigarettes?

every day	some days, but not every day

If current smoker, how many cigarettes a day do you smoke?

5 or less	6-10	11-20	21-30	31 or more

If current smoker, how soon after you wake up do you smoke your first cigarette?

within 5 minutes	6-30 minutes	31-60 minutes	after 60 minutes

If current smoker, are you interested in quitting?

Ready to quit	Thinking about quitting	Not ready to quit

If former smoker, how long has it been since you last smoked?

1-3 months	less than 1 month	3-6 months	6-12 months	1-5 years	5-10 years	10 years +

Additional Findings: Tobacco user, are you

Chain smoker	Chews fine cut tobacco	Chews loose leaf tobacco	Chews plug tobacco	Chews tobacco
Chews twist tobacco	Heavy cigarette smoker (20-39 cigs/day)	Light cigarette smoker ((1-9 cigs/day)	Moderate cigarette smoker (10-19 cigs/day)	Pipe smoker
Rolls own cigarettes	Snuff user	Trivial cigarette smoker (less than one cigarette/day)	User of moist powdered tobacco	Very heavy cigarette smoker (40+ cigs/day)

Additional Findings: Tobacco Non-User, are you

Aggressive non-smoker	Current non-smoker	Current non-smoker	past smoking history unknown
Does not use moist powdered tobacco	Ex-cigar smoker	Ex-cigarette smoker	Ex-cigarette smoker amount unknown
Ex-heavy cigarette smoker (20-30/day)	Ex-light cigarette smoker (1-9/day)	Ex-moderate cigarette smoker (10-19/day)	Ex-pipe smoker
Ex-trivial cigarette smoker (<1/day)	Ex-user of moist powdered tobacco	Ex-very heavy cigarette smoker (40+/day)	Intolerant ex-smoker
Intolerant non-smoker	Never chewed tobacco	Never used moist powdered tobacco	Non-smoker for medical reasons
Non-smoker for personal reasons	Non-smoker for religious reasons	Tolerant ex-smoker	Tolerant non-smoker

Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)

SOCIAL HISTORY (please use an "X" to indicate your answer)

Marital status

Never married	Married	Divorced	Separated	Widowed	Partnered / significant other

Have you had sex in the past 12 months (vaginal, oral, or anal)?

No	Yes	With Men only	With Women only	With both Men and Women

Do you use protection?

No	Yes

Prevention strategies discussed?

Abstinence	Condoms	Other

Have you ever had a Sexually transmitted disease?

No	Yes	If yes please specify (Chlamydia, Syphilis, Herpes, Other)

Sexual abuse

No	Yes	In the past	In current relationship	Other

Last menstrual period (dd/mm/yyyy)

ALCOHOL HISTORY (please use an "X" to indicate your answer)

Did you have a drink containing alcohol in the past year?

No	Yes

If Yes, how often?

Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

1 or 2 drinks	3 or 4 drinks	5 or 6 drinks	7 to 9 drinks	10 or more drinks

How often did you have 6 or more drinks on one occasion in the past year?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily

DRUG HISTORY (please use an "X" to indicate your answer)

Have you ever used drugs other than those for medical reasons in the last 12 months?

No	Yes

Are you currently using

PCP	Ketamine	Marijuana	Prescription opiates	Ecstasy
LSD	Crack	Methamphetamine	Heroin	Cocain

How many months ago did you last use?

Are you in a treatment program?

No	Yes

Have you ever injected drugs?

No	Yes

Is there a minor (18 years or younger) at risk at home?

No	Yes

PHQ9

Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "x" to indicate your answer) *Durante las últimas 2 semanas, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas?* *(Marque con un "¬x" para indicar su respuesta)*	Not at all *Ningún día*	Several days Varios días	More than half the days Más de la mitad de los días	Nearly every day Casi todos los días
1) Little interest or pleasure in doing things *Poco interés o placer en hacer cosas*	**0**	**1**	**2**	**3**
2) Feeling down, depressed, or hopeless *Se ha sentido decaído(a), deprimido(a) o sin esperanzas*	**0**	**1**	**2**	**3**
3) Trouble falling or staying asleep, or sleeping too much *Ha tenido dificultad para quedarse o permanecerdormido(a), o ha dormido demasiado*	**0**	**1**	**2**	**3**
4) Feeling tired or having little energy *Se ha sentido cansado(a) o con poca energía*	**0**	**1**	**2**	**3**
5) Poor appetite or overeating *Sin apetito o ha comido en exceso*	**0**	**1**	**2**	**3**
6) Feeling bad about yourself or that you are a failure, or have let yourself or your family down *Se ha sentido mal con usted mismo(a) – o que es un fracaso o que ha quedado mal con usted mismo(a) o con su familia*	**0**	**1**	**2**	**3**
7) Trouble concentrating on things, such as reading the newspaper or watching television *Ha tenido dificultad para concentrarse en ciertas actividades, tales como leer el periódico o ver la television*	**0**	**1**	**2**	**3**
8) Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual *¿Se ha movido o hablado tan lento que otras personas podrían haberlo notado? o lo contrario – muy inquieto(a) o agitado(a) que ha estado moviéndose mucho más de lo normal*	**0**	**1**	**2**	**3**
9) Thoughts that you would be better off dead or of hurting yourself in some way *Pensamientos de que estaría mejor muerto(a) o delastimarse de alguna manera*	**0**	**1**	**2**	**3**