

COASTAL MEDICAL CLINIC REGISTRATION FORM

(Please Print)

Today's date:				Permission to use Email for appointment confirmation: <input type="checkbox"/> Yes <input type="checkbox"/> No			
PATIENT INFORMATION							
Patient's last name (as written on insurance):		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		Email Address:		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Phone #() Alt Phone #()		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ()		
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Website
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other	
Do you currently have an Advanced Directive in place? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide copy to physician for records. If no, would you like to create one for your records? <input type="checkbox"/> Yes <input type="checkbox"/> No							

INSURANCE INFORMATION							
(Please give your insurance card and photo ID to the receptionist.)							
Person responsible for bill:		Birth date: / /	Address (if different):			Phone #() Alt #()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:		Employer:		Employer address:		Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Welfare (Please provide coupon)		<input type="checkbox"/> Other		
Insurance Holder's name:		Holder's S.S. no.:		Birth date: / /	Group no.:		Policy no.:
							Co-payment: \$
Patient's relationship to Ins Holder:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):			Insurance Holder's name:		Group no.:		Policy no.:
Patient's relationship to Holder:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY							
Name:				Relationship to patient:		Home phone no.: ()	Work phone no.: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.							
_____ <i>Patient/Guardian signature</i>						_____ <i>Date</i>	

COASTAL MEDICAL CLINIC

Policy Acknowledgment

- ▲ Walk-ins will be seen based on the reason for the visit and openings or times in which we are able to accommodate them around our scheduled patients.
- ▲ We do not have access to financial or insurance records from Medical Arts Clinic.

PRESCRIPTIONS

- ▲ If you need a prescription refill and have not been seen within the **past three months**, you are required to be seen prior to the refill.
- ▲ New prescriptions or medications that have not been written by our office **will not be refilled**. You must be seen in order for us to fill them.
- ▲ If you are requesting a refill of any **NARCOTIC medication** and have not been seen within the past month, you are required to be seen.
- ▲ To request prescription refills, **please contact your pharmacy**. They will fax the request to us for approval. If approved, **prescription refill requests will be completed within 48 to 72 hours**.
- ▲ To make sure you do not run out of medication please call and schedule an appointment prior to taking your last dose.
- ▲ Walk-ins will not be accepted for refill requests.

NARCOTIC PRESCRIPTIONS

- ▲ Any patient requesting narcotics as a new prescription or for refills is agreeing to **subject to a urine drug screen** at the time of visit.
- ▲ Any patient who refuses to provide a urine specimen will be denied prescriptions for all narcotics regardless of their necessity.
- ▲ Any patient who is unable to provide a urine sample at the time requested will be asked to provide a saliva swab for the drug screen.
- ▲ If at any time the drug screen shows that the medication prescribed is not being taken the patient will be discharged from Coastal Medical Clinic.
- ▲ If at any time the drug screen shows that the patient is taking medication other than prescribed or illegal drugs and the nurse or practitioner was not informed, they will be discharged from Coastal Medical Clinic.
- ▲ In receiving a narcotics prescription the patient is agreeing to take the medication **exactly as prescribed**.
- ▲ The patient agrees that if at any time they receive narcotic prescriptions from another physician's office and have them filled during the same time period as Coastal Medical Clinic, they will be immediately discharged.
- ▲ The patient agrees to use only one pharmacy to have their medications filled.

Patient Name: _____

Date Of Birth: ____/____/____

Patient Signature: _____

Date: _____

DATE:
DATES REVISED:

HEALTH HISTORY

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

NAME <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
PREVIOUS OR REFERRING DOCTOR:	DATE OF LAST PHYSICAL EXAM:	

PERSONAL HEALTH HISTORY

CHILDHOOD ILLNESS:	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio		
Immunizations and dates:	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia	
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox	
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>	

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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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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	<input type="checkbox"/> Sedentary (No exercise)				
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	# of meals you eat in an average day?				
	Rank salt intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low	
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you considered stopping?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever experienced blackouts?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you prone to "binge" drinking?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you drive after drinking?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tobacco	Do you use tobacco?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks per day		<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit			

Drugs	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personal Safety	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive and/or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
FATHER			Children	<input type="checkbox"/> M	
MOTHER				<input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		GRAND MOTHER <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		GRAND FATHER <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		GRAND MOTHER <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		GRAND FATHER <i>Paternal</i>		

MENTAL HEALTH

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

WOMEN ONLY

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

MEN ONLY

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

OTHER PROBLEMS

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

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

COASTAL MEDICAL CLINIC

Conditions of Service

(For both insured and self-pay patients)

Patient: _____ DOB _____ Acct# _____

Assignment of Benefits and Release of Patient Healthcare Information

I hereby authorize Coastal Medical Clinic to release patient healthcare information, compiled from the medical records pertaining to my services, in accordance with the policy of the clinic and Texas law, to facilitate reimbursement by a health benefit plan or third party payor, including but not limited to, my insurance carrier, Medicare, Medicaid and any other payer or agency.

I also hereby authorize payment of insurance benefits under the terms of my policy directly to Coastal Medical Clinic for services rendered. I am financially responsible and will pay for charges not covered by my insurance plan.

Financial Agreement and Statement of Responsibility

For and in consideration of services rendered or to be rendered by Coastal Medical Clinic, I agree to pay said clinic for all services and charges. I understand that I am responsible for any health insurance deductibles, coinsurance and non-covered charges. **Payment in full is due at time services are rendered or payment arrangements are to be made prior to your appointment.**

Consent to Medical Treatment by Physician

I, or authorized representative/legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services, which may include routine diagnostic procedures and such medical treatment as the physician, his/her assistants or his/her designees consider to be necessary in his/her judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to results of treatment or examination at Coastal Medical Clinic.

Consent to Medical Treatment by Physician Assistant

I, or authorized representative/legal guardian acting on behalf of patient, do hereby consent to receiving general medical services from a physician assistant. I fully understand that a physician assistant IS NOT A PHYSICIAN. I further acknowledge that the general medical services provided to me by a physician assistant are the responsibility of the physician providing the services at Coastal Medical Clinic both professionally and legally, for acts of such allied health personnel rendered during the care and treatment of his/her patients.

Release of Patient Healthcare Information

I hereby authorize Coastal Medical Clinic to release patient healthcare information, in accordance with the policy of the clinic, as is necessary to healthcare providers to facilitate reimbursement by a health benefit plan or personnel of another healthcare entity for the sole purpose of providing current continuum of care including, but not limited to fax, mail or electronic submission.

Acknowledgment of Notice of Privacy Practice

I acknowledge I have reviewed this office's Notice of Privacy Practice, which explains how my medical information will be used and disclosed. This notice is posted on the wall next to the check-in window, but I understand I am entitled to receive a copy of this document upon request.

The above authorizations will remain in effect until revoked by me in writing. A photocopy of these authorizations is to be considered as valid as the original. I have read and understand these conditions.

Patient/Guarantor Signature

Date