WOODLANDS
FAMILY MEDICINE CLINIC

REGISTRATION FORM

(Please Print)

Today's date: | PCP:

PATIENT INFORMATION

Patient's last name: | First: | Middle: | Marital status:

Is this your legal name? ☐ Yes ☐ No | If not, what is your legal name? | Former name: | Birth date: / / | Sex: ☐ Male ☐ Female

Street address, City, State, Zip: | Social Security #: | Home phone #: ( )

P.O. box, City, State, Zip:

Occupation: | Employer: | Employer phone #: ( )

Who may we thank for referring you to our clinic?
Name: | Phone #:

Please list any other family members seen here:

Email Address:

RESPONSIBLE PARTY INFORMATION

Person responsible for bill: | Birth date: / / | Address (if different than patient): | Home phone #: ( )

Is this person a patient here? ☐ Yes ☐ No

PRIMARY INSURANCE INFORMATION

(Please give your insurance card and Driver's license or State ID to the receptionist with completed paperwork)

Is this patient covered by insurance? ☐ Yes ☐ No | Insurance company name:

Insurance claims address:

Insurance phone #:

Subscriber/ Policy holder name: | Subscriber Social security # | Subscriber Birth date: / / | ID/Policy #: | Group #:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

SECONDARY INSURANCE INFORMATION

Secondary Insurance name & phone #: | Subscriber/ Policy holder name: | Subscriber Birth Date: / / | ID/Policy #:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: | Group #:

IN CASE OF EMERGENCY

Name of local friend or relative: | Relationship to patient: | Home phone #: ( ) | Work phone #: ( )

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 Family Medicine Clinic & Women's Health or insurance company to release any information required to process my claims.

_______________________________ Patient/Guardian signature

_______________ Date

MEDICAL HISTORY

DATE: ______________________

PATIENT NAME: ____

ARE YOU EMPLOYED? YES ☐ NO ☐ TYPE OF WORK: ______________________________________

MARITAL STATUS

SINGLE ☐ MARRIED ☐ SEPERATED ☐ DIVORCED ☐

NAME OF SPOUSE: ____

PREVIOUS SURGERIES: (NAME & DATE)

____

____

MAJOR ILLNESSES OR INJURIES:

____

____

FAMILY HISTORY	*AGE IF LIVING*	*AGE OF DEATH*	*PRESENT CONDITION OR CAUSE OF DEATH*
FATHER			
MOTHER			
BROTHER(S)			
SISTER (S)			
CHILDREN			

PLEASE INDICATE IF A PARENT, BROTHER OR SISTER HAS EVER HAD ANY OF THE FOLLOWING:

☐ ARTHRITIS ☐ ASTHMA ☐ BREAST CANCER ☐ COLON CANCER ☐ COLON POLYPS

☐ TUBERCULOSIS ☐ DIABETES ☐ THYROID ISSUES ☐ HIGH CHOLESTEROL ☐ STOMACH ULCERS

☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ HEART TROUBLE

WHEN WAS YOUR LAST TETANUS SHOT? ______________________

CURRENT HEIGHT: __________ CURRENT WEIGHT: __________

HAVE YOU EVER SMOKED? YES ☐ NO ☐ IF YES, HOW MUCH ______________________________

DO YOU DRINK ALCOHOL? YES ☐ NO ☐ IF YES, HOW MUCH ______________________________

HAVE YOU EVER USED RECREATIONAL DRUGS? YES ☐ NO ☐

WOODLANDS
FAMILY MEDICINE CLINIC

NURSE PRACTITIONER CONSENT

This facility has on staff Nurse Practitioners to assist in the delivery of medical (Family Practice Specialty) care.

A Nurse Practitioner is not a doctor. A nurse Practitioner is a Registered Nurse who has received advanced education and training in the provision of healthcare. A Nurse Practitioner can diagnose, treat and monitor common illnesses and chronic diseases as well as provide health maintenance care. In addition, the Nurse Practitioner may treat minor lacerations and other minor injuries.

I have read the above and herby consent to the services of a Nurse Practitioner for my healthcare needs.
I understand that at any time I can refuse to see the Nurse Practitioner and request to see a Physician.

Patient Signature: ______________________________ Date: __________________________

Physician Financial Disclosure Notification

Hazem Elzufari MD PA has a financial investment in Aspire Hospital, Woodlands Vascular Access and Baylor CHI St Luke's Freestanding Emergency Centers.

Patient Initials: ______________________________ Date: __________________________

NOTICE OF PRIVACY PRACTICE/HIPPA

Family Medicine Clinic and Women's Health has provided a copy of their HIPPA and Privacy Practice Notification for review and will provide a copy at your request.

Patient Initials: ______________________________ Date: __________________________

No-Show Policy

Family Medicine Clinic and Women's Health imposes the following policy with regard to patients who fail to keep their scheduled appointments. Patients who fail to come in for their scheduled appointment or do not contact our office to cancel or reschedule their appointment at least 24 hours prior to their scheduled appointment time, shall be subject to a **"No Show" penalty of $25.00. Insurance plans will not cover charges for No Show fees**. No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

Medicaid: If a patient has Medicaid and no-shows in our office 3 times the **patient will be terminated from our practice** and will no longer be able to make any future appointments in our office.

By signing below you are acknowledging that you have read and understand the above information.

Patient Signature: ______________________________ Date: __________________________

Schedule II Prescriptions

Due to increased work load and time spent processing prescriptions, as of November 6,2014 we will charge a $10.00 processing fee for **ALL CII prescriptions** that have to be written and picked up at the office. This **will not** be billed to your insurance. The money will be due when the prescription is picked up. (Per state regulations: Medicaid and workers compensation patients are excluded)

Patient Signature: ______________________________ Date: ______________________________________

Family Medicine Clinic
& Women's Health

M. Hazem ElZufari, MD
Anjali Reddy, ANP
Danielle Allen, ANP

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

FAMILY MEDICINE CLINIC & WOMEN'S HEALTH
9000 FOREST CROSSING DRIVE THE WOODLANDS, TX 77380
PHONE: 281-681-0616
FAX: 281-419-0445

Patient Name: ____
(Last Name) (First Name)

Date of Birth: ____________________

Address: ____

Phone: ______________________________

The information you may release subject to this signed release form as follows:

___ Complete Record ___ Lab Reports ___ Operative Reports ___ History and Physical

___ Radiology Reports ___ Hospital Reports ___ Progress Notes ___ Pathology Reports

___ Medical Record(s) ___ Care Plan ___ Treatment Record(s) ___ Other (Please Specify)

Your initials are required to release the following information:

___ Mental health records (excluding psychotherapy notes) ___ HIV/AIDS Test Results/Treatment
___ Drug, alcohol or substance abuse records ___ Genetic Information (all test results)

I authorize the following to disclose my health information:

Person/Organization Name: ______________________________________

Address: ____

Phone: ________________________

Who can receive my health information:

Family Medicine Clinic & Women's Health
9000 Forest Crossing The Woodlands, TX 77380
Phone: 281-681-0616 Fax: 281-419-0445

Signature of patient or legal representative: ______________________________________

Patient's Name: ______________________________ Date: ____________________