Seminole Family Medical Clinic

207 N.W. 8th Street Seminole, Texas 79360

Dr. Wendell Parkey – Brock Morris, FNP – Kristie Morris, FNP
Billie Armstrong, FNP – Dr. Leila Myrick

Today's Date: _____/_____/_____

First Name: _____Middle: _____Last: _____

Date of Birth:_____/_____/_____ Age: ____ Female__ Male__ SS#_____/___/_____ DL #_____

Mailing Address: _____City: _____State:_____Zip:_____

Phone #: _____ Alternate #: _____

Email address: _____ (for portal registration)

Patients Marital Status: _____ Minor _____Single ____Married _____Separated_____ Divorced_____Widow/er

Race:_____ Ethnicity:_____ Preferred Language:_____

Employer: _____ Phone: _____Address: _____

Emergency Contact Name: _____ Date of Birth___/___/_____

Phone #_____Relationship to Patient_____

Person Responsible for Patient/Child

First Name:_____ Middle Name: _____ Last Name:_____

DOB:___/___/_____ Phone #:_____ SS#:_____-_____-_____

Mailing Address:_____ City:_____State:_____Zip Code_____

Employer: _____ Phone #_____Address:_____

Medical Insurance/ Medicare/ Medicaid Information- Please fill out

Name of Policy Holder: _____ DOB:____/____/_____ SS #_____-_____-_____

I.D#: _____ Group #: _____Phone: _____

Insurance Company Name: ____BCBS ___ AETNA ___ CIGNA ___ UHC ___ Other:_____

MEDICARE #:_____ MEDICAID #: _____

DOB: _____ Employers' Name: _____

Do you have a Second form of Insurance?_____Yes_____No

Name of Insurance: _____

I.D#: _____Group #: _____Phone: _____

Name of Policy Holder: _____S.S. # _____

PREFERRED PHARMACY:_____

PHARMACY ADDRESS:_____

MEMORIAL HOSPITAL
SEMINOLE HOSPITAL DISTRICT

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Patients Full Name: _____Ethnics: _____

Personal History:

Have you ever **Yes or No / If Yes, Please explain and provide date:**

Operations: ____No ____Yes _____

Advised to have surgery ____No ____Yes _____

Current Medical History:

Please mark with an X:

Diabetes:		Vericose Veins:		Swelling Legs/Feet:	
High Blood pressure:		Hemorrhoids:		Urination Difficulties:	
Nervous Condition:		Asthma:		STD's:	
Tuberculosis:		Blood Urine:		Eye Conditions:	
Heart Trouble:		Chronic Cough:		Loss of Hearting:	
Cancer:		Fainting/Dizziness:		Measles/Rubella:	
Arthritis:		Allergies:		Frequent Diarrhea:	
Seizure Disorder:		Frequent Headaches:		Anemia:	
Hepatitis:		Jaundice:		Chicken Pox:	
Rheumatic Fever:		Joint Pain:		Mumps:	
Skin Rash:		Paralysis:		Difficulty Swallowing:	
Stomach Ulcer:		Shortness of Breath:		Chronic Fatigue:	
Heart burn:		Depression:		Nervousness:	
Weight Gain:		Weight Loss:		Chronic Pain:	

Other: _____

Do you smoke: __ N ___Y, Chew: __N__Y, Dip: __N__Y, How many cig/packs per day_____Quit, if so when? _____

Do you drink alcohol: __ N ___ Y, if so how much explain_____Quit, if so when? _____

Family History:

Has anyone in your family ever had: **Yes or No / If Yes, Please explain:**

Stroke: ____No ____Yes _____

Cancer: ____No ____Yes _____

High Blood Pressure: ____No ____Yes _____

Tuberculosis: ____No ____Yes _____

Diabetes: ____No ____Yes _____

Heart Attack: ____No ____Yes _____

Bleeding Tendency: ____No ____Yes _____

Other: ____No ____Yes _____

Up to date on Immunizations: ___Yes ___No *please provide Immunization chart under the age of 17.*

Please provide last date on the following information:

Flu Shot: _____ Pneumonia Vaccine: _____ T-Dap: _____ Zoster Vaccine: _____

Last Menstrual Period: _____ Mammogram: _____ Pap smear: _____ Labs: _____

Prostate Specific Antigen: _____ Colonoscopy: _____ Bone Density Test: _____

Do you have any Allergies to Medications: No___ Yes___Medications:_____

Please have all original medication bottles with you at time of visit or a list of all updated medications including vitamins

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Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the healthcare services, MHCS provider creates and maintains health records and other information describing among other things my health history, symptoms, examinations and test results, diagnosis, treatment, and any plans for future care or treatment.

I have been provided with a notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practice and prior to implementation with mail a copy of any revised notice to the address I have provided.

I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting and arranging for medical review, legal services and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

INSURANCE NON-ALLOWABLE CHARGE: I understand that some injectable drugs are considered experimental/ investigations such as, but not limited to allergy injection(s), and may not be covered by insurance, I agree to pay for any portion of the drugs or services that are not payable by my insurance, if they are deemed to be experimental or investigational by the insurance company at the time my claim is submitted for payment to the insurer.

THIS AGREEMENT WILL APPLY FOR A YEAR FROM THE DATE SIGNED BELOW.

By signing this form, I consent to the use and disclosure of protected health information about me for the purpose of treatment, payment and healthcare operations. I have the right to revoke this consent, in writing except where disclosures have already been made in reliance on my prior consent.

This Consent is given freely with the understanding that:

1. Any and all records, weather written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment, or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment, or health care separations, be restricted. I also understand that the Practice and I must agree to any restriction in writing that I requested on the disclosure of my Protected Health Information: and agree to terminate any restricts in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

Patient Name Printed	**Date**
Patient Signature (or Guardian)	**Patient's DOB**

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IMPORTANT!!

PLEASE READ BEFORE PROCEEDING!

When registering please present ALL medical Insurance cards that are current to the Receptionist.
Payment is expected at the time of service. Private pay patient will have to pay in full at time of service or sign a payment installment contract. The enclosed forms must be filled out completely and signed by the patient or the legal guardian if patient is a minor.

As of 1/1/2018: ANCILLARY SERVICES.
Please note that effective immediately any labs that are done in the clinic will be billed through Seminole Memorial Hospital District. You will receive a statement from the Hospital for these services, if there is a balance due from the patient for services provided. The payment made in the Clinic is for the Clinic visit only.

Labs that will be billed through Seminole Memorial Hospital District:

- **Pregnancy Test**
- **Strep A/B**
- **Flu A/B**
- **EKG**
- **Glucose Finger Stick**

Please sign below stating that you have read and understand this statement. If you have questions, please feel free to ask the receptionist and she will help you.

I certify that I have read the above information and understand that I am financially responsible for all charges whether or not covered by my insurance.

_____

Print Name of Patient

_____

Signature of Responsible Party

_____

Date

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUAL / FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Health care Portability Act of 199 (HIPPA), in order for your health care provider or Staff to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to do so. In the event of critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ I DO NOT AUTHORIZE Seminole Family Medical Clinic Staff to release any or all information concerning my medical care to the following individuals.

_____ I DO AUTHORIZE Seminole Family Medical Clinic Staff to verbally release any or all information concerning my medical care to the following individuals.

_____

Name **Relationship to patient**

_____

Name **Relationship to patient**

_____

Name **Relationship to patient**

X_____ **X**_____

Print Patients Name or Guardian **Signature of Patient or Guardian**

Patient's DOB: _____**Last 4 SS#:** _____**Date:** _____

IF THE PERSON CALLING OR REQUESTING INFORMATION IS NOT ON THIS FORM, WE ARE NOT PERMITTED TO RELEASE ANY INFORMATION. ***NO EXCEPTIONS***

Comments for the Staff:_____

REVISED 07/2019

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Consent for Treatment

MHCS provider will provide necessary health care including the diagnosis and treatment of illness or injuries. The undersigned having read and expressed understanding of this document by the signature below does hereby agree to be medically attended and treated by the aforementioned physician. I further consent to the performance of those diagnostic procedures, examinations, and rendering of medical staff and their assistants as necessary in the medical staff's judgment. I understand that this consent form will be valid and remain in the effect as long as I am under the care MHCS providers. This form has been fully explained to me and I understand its contents.

_____ _____

Patient's signature (Guardian) **Date**

AUTHORIZATION FOR MEDICAL TREATMENT FOR PERSON(S) UNDER 17 YEARS OF AGE

Any person 17 years of age or under cannot authorize medical treatment for themselves, or for anyone else. To assist in obtaining treatment, we are providing this from which you may have ready with person caring for your child, in the hands of the older child, on file with your hospital emergency room, or on file at your doctor's office. Both parents should sign this form. Witness should be persons other than, any persons who live in that household. This form does not have to be notarized.

_____ _____

Print Child's Name **Date of Birth**

You are authorized to perform or arrange for whatever treatment you may consider necessary.

_____ _____

Mother's or Legal Guardian's Signature **Date**

_____ _____

Father's or Legal Guardian's Signature **Date**

****THIS FORM MUST BE SIGNED BEFORE PATIENT IS SEEN****