Timarron
Family Medicine
Esthetics
Regenerative Medicine

TIMARRON FAMILY MEDICINE
MEDICAL HISTORY FORM

TODAY'S DATE: _____

NAME:_____
DATE OF BIRTH: _____
PHARMACY NAME/ADDRESS: _____

OCCUPATION: _____
ARE YOU? MARRIED SINGLE PARTNER
Are you ALLERGIC to any medicines? YES NO
IF YES, please list the medicine and the type of reaction you had from taking that medicine.

_____
_____
_____

List all your prescription medicines indicating the dose of each pill or tablet or liquid and when you take each medicine.

_____
_____
_____

List any over-the-counter medicines, vitamins and supplements you take most days including if you take a daily aspirin:

_____
_____
_____

Have you had any recent medicine changes? YES NO
IF YES, which medicines or dosages are new?

_____
_____
_____

List all your current medical conditions such as high blood pressure, high cholesterol, diabetes, heart failure, hypothyroidism, back pain, arthritis, etc.

_____
_____
_____

List all surgeries you have had and the approximate year the surgery was done.

_____
_____
_____

List any times you were admitted to the hospital and list the diagnosis (reason(s)) for admission and the approximate year of the admission.

_____
_____
_____

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FAMILY HISTORY FORM

☐ **NO SIGNIFICANT FAMIY HISTORY IS KNOWN**

PLEASE PLACE AGE OF ONSET DIAGNOSIS	High Blood Pressure	High Cholesterol	Diabetes	Thyroid Disorders	Breast Cancer	Blood Clots	Glaucoma	Stroke	Aortic Aneurysm	Skin Cancer	Prostate Cancer	Colon Cancer	Pancreatic Cancer	Ovarian Cancer	Heart Attacks or bypass surgery before age 55	Other:
MOTHER																
FATHER																
BROTHER																
SISTER																
CHILD																
MATERNAL GRANDMOTHER																
MATERNAL GRANDFATHER																
PATERNAL GRANDMOTHER																
PATERNAL GRANDFATHER																
OTHER: (PLEASE EXPLAIN)																

Are you a current smoker? YES NO
IF YES, how much do you smoke per day now? _____ packs per day
How many years have you smoked? _____ Do you want to quit? YES NO
Are you a former smoker? YES NO How many years did you smoke? _____
When did you stop smoking?_____
Do you drink any alcoholic beverages? YES NO IF YES, what types? beer wine liquor
On average, how many drinks per week? _____
Do you think you might have a problem with alcohol? YES NO
Do you have an addiction problem with any legal or illegal drugs? YES NO

When was your last immunization?
Tetanus / Pertussis _____ Pneumonia _____
Shingles _____ Flu _____

Have you ever had a colonoscopy? YES NO IF YES, when was your last one? _____
Were you diagnosed with: POLYPS DIVERTICULOSIS NEITHER
When was your last eye exam?_____ Who is your eye doctor?_____
When was your last physical/labs (for females – pap / mammogram)?
_____
List any specialists you see and why you see them:
_____
_____
_____

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PATIENT REGISTRATION FORM

PATIENT DEMOGRAPHICS

First Name	Last Name
Date of Birth	Social Security No
Address	City
State	Zip
Home Phone	Cell Phone
Marital Status	Email
Employer	Occupation
Pharmacy Name	Pharmacy Location

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Policy Subscriber	Policy Subscriber
Subscriber DOB	Subscriber DOB
Subscriber SSN	Subscriber SSN
Subscriber Employer	Subscriber Employer

EMERGENCY CONTACT INFORMATION

Name	Name
Phone	Phone
Relationship to Patient	Relationship to Patient

I consent to receive communications from Timarron Family Medicine in an electronic form and agree that all terms, conditions, agreements, notices, disclosures, and other communications that Timarron Family Medicine provides to you electronically satisfy any legal requirement that such communications would satisfy as if it were in writing. _____

By signing below, I attest that the information provided above is true and accurate.

Signature of Insured / Guardian: _____

Date: _____

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PAYMENT POLICY

All copays and deductible amounts are due at time of service. We accept cash, personal checks as well as MasterCard, Visa and Discover. There will be a $25.00 charge for all returned checks. Your services are always filed to your insurance; usually within 2 business days of your visit. Payment from your insurance is expected within 45 days of said visit. If you are not on one of the many insurances that we accept or this is a third party billing situation then full payment is expected at the time services are rendered. If there is a patient balance due on your account you will receive monthly statements from the office and any accounts over 60 days past due are subject to collections.

There will be a 1.5% finance charge on accounts after 30 days. If the account remains unpaid for 90 days and there has been no attempt by the patient or legal guardian to make payment arrangements, or failure to comply with previously set payment schedule the account may be turned over to a collection agency. It is up to the patient to know your insurance coverage and to keep us notified of any changes with your insurance policy. Any non-covered services will be your responsibility and will be billed directly to you.

Recognizing that everyone's time is valuable and the appointment time is limited, we ask that you provide a 24 hour notice if you are unable to keep your appointment. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, we reserve the right to charge a fee of $60.00 for each missed (No Show) appointment, if you cancel or miss a Physical Exam the fee increases to $100.00.

Patients not signed up for a Tiered Access Health Plan will be charged a $25.00 Administration Fee for their first three visits of the year. This fee is in response to the increasing cost of running a business in today's health care environment. This fee is non-negotiable. For more information on the Tiered Access Health Plan please see the front desk or visit our website at www.timarronfamilymedicine.com.

I consent to the treatment for the care of the patient indicated on this registration form. I hereby authorize assignment of all medical insurance benefits to Timarron Family Medicine for services rendered. Authorization is hereby granted to release information as may be necessary to process and complete insurance claims. I also authorize release of information necessary to complete referrals to other healthcare facilities as deemed necessary by my primary physician.

Patient/Legal Guardian Signature: _____

Date: _____

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PROTECTED HEALTH INFORMATION (PHI)

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients' rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

By signing this consent you authorize Timarron Family Medicine to release all health information, including, cosmetic treatment services, to the following individuals:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

_____
Patient Name

_____ Date: _____
Patient Signature

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Notice Summary of Privacy Practices

Identifying the Rights of an Individual (patient)

- You have the right to receive a "Notice of Privacy Practices" from any healthcare provider from whom you receive health care
- You have the right to authorize any use or disclosure of protected health information for a purpose not covered by the "Notice of Privacy Practices" for use in treatment, payment or healthcare operations.
- You have the right to have a personal representative, a designated person delegated the authority to consent to, or authorize the use or disclosure of protected health information.
- You have the right to request that a healthcare provider, health plan, or healthcare clearing house not use or disclose certain protected health information, and to request that the provider make reasonable efforts to keep the communications of protected health information confidential.
- You have the right to know the parties to whom a healthcare provider, health plan, or health clearing house has disclosed protected health information (known as disclosure accountability).
- You have the right to inspect, obtain copies of, and request corrections in protected health information maintained by a healthcare provider, health plan, or health care clearing house.

Identifying the Rights of Healthcare Providers

- The privacy rule allows providers to call patients by name in the waiting room, contact them with appointment reminders or test results, contact them with information about recommended treatment alternatives, or contacting them to provide information about health-related benefits and services offered by the practice.
- The practice may use or disclose patient's *personal health information* (PHI) for the purposes of treating the patient, obtaining payment for the services provided, and to conduct certain health care operations permitted under the Privacy Rules. We will use patient's PHI to provide, coordinate, or manager their health care or any related services. This includes the coordination or management of their healthcare with a third party that is involved in their care and treatment. PHI will be used as needed to obtain payment for the care provided. It will also include the disclosure of information if necessary to a collection agency in order to obtain payment for services.
- A provider may be required to disclose PHI as required by law in cases of abuse or neglect, for communicable diseases, for health agency involvement, for requests from the FDA, for legal proceedings, in cases of criminal activity, and other reasons
- A practice may charge a fee for no show appointments

While an individual (patient) has substantial control, the practice will have the right to offset or deny unreasonable requests for such things as restrictions, requested amendments or changes to an individual's records, etc.

Notice of Acknowledgement

Name of Patient: _____ DOB: _____

Signature: _____

Relationship to Patient: _____

Available by Request, Full Notice of Privacy Practices.