KELLER FAMILY MEDICAL CENTER
REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle: Home or Cell phone no:

Name you wish to be called: Marital status: Single Married Divorced Widow(er) Separated Partner Birth date: / / Age: Sex: M F T

Street address: Apartment No:

City: State: ZIP Code: Email Address:

Occupation: Employer: Employer phone no: ( )

Race: (Circle one)
White Hispanic Asian
Black/African Amer. Other Race
American Indian

Ethnicity:
- ○ Hispanic or Latin
- ○ Not Hispanic
- ○ Refuse to report

Primary Language:

Referred to clinic by (please check one box):

❑ Insurance ❑Family ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Policy Holder's Name: Birth date: / / Address (if different): Home phone no: ( )

Is this person a patient here?

Occupation: Employer: Employer address: Employer phone no: ( )

Relationship to patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance: Policy Holder's name: Group no: Policy no:

Relationship to patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative: Relationship to patient: Home phone no.: ( ) Cell phone no: ( )

By my signature below, I hereby authorize payment of medical benefits directly to Keller Family Medical Center for services rendered. Authorization is hereby granted to Keller Family Medical Center to release information as may be necessary to process and complete my claim. I understand I am financially responsible for this account.

Patient/Guardian signature ***Date***

Confidential

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

– Symptoms –

Check (✓) conditions you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

– Conditions –

Check (✓) conditions you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

– Medications –

List medications you are currently taking.

_____

_____

_____

_____

Pharmacy Name _____ Phone _____

– Allergies –

_____

_____

_____

_____

_____

– Health History –

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– Family History –

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Strokes	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

– Hospitalizations –

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates_____

Serious Illness/Injuries	Date	Outcome

– Pregnancies –

Year of Birth	Sex of Birth	Complications if any

– Health Habits –

Check (✓) which you use and how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

– Occupational –

Check (✓) if your work exposes you to:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

[illegible]ed By

Date

Wellness Update

Patient name	Date of birth	Today's date

How often do you have these symptoms?

(Please check one box in the Severity section and Frequency section)

	SEVERITY			FREQUENCY		
	Mild	Moderate	Severe	Never or Occasionally	Seasonal	Most of the Year/Daily
Watery Eyes	☐	☐	☐	☐	☐	☐
Itchy Eyes	☐	☐	☐	☐	☐	☐
Red Eyes	☐	☐	☐	☐	☐	☐
Runny Nose	☐	☐	☐	☐	☐	☐
Stuffy Nose	☐	☐	☐	☐	☐	☐
Itchy Nose	☐	☐	☐	☐	☐	☐
Frequent Sneezing	☐	☐	☐	☐	☐	☐
Post Nasal Drip	☐	☐	☐	☐	☐	☐
Chronic/Seasonal Colds	☐	☐	☐	☐	☐	☐
Sinus Pressure/Sinus Headache	☐	☐	☐	☐	☐	☐
Dry, Red, or Itchy Skin	☐	☐	☐	☐	☐	☐
Consistent Coughing	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Itchy Mouth / Throat Clearing	☐	☐	☐	☐	☐	☐
Restless Sleep / Snoring	☐	☐	☐	☐	☐	☐
Daytime Fatigue	☐	☐	☐	☐	☐	☐

How often do you use the following?

	Never or Occasionally	Seasonal	Most of the Year/Daily
Over-the-Counter Antihistamine (Allegra®, Claritin® Zyrtec®, Benadryl®, etc)	☐	☐	☐
Over-the-Counter Nasal Spray	☐	☐	☐
Prescribed Allergy Medication/Spray	☐	☐	☐
Neti Pot	☐	☐	☐
Steroids	☐	☐	☐

Patient/Guardian signature	Date	Patient phone

FOR PROVIDER USE ONLY:

Order Allergy Test: ☐ Yes ☐ No

Date of last Physical exam: __/__/__

Provider signature: _____

Date: __/__/__

KELLER FAMILY MEDICAL CENTER
Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Keller Family Medical Center to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by Keller Family Medical Center describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Keller Family Medical Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer, 808 Keller Parkway, Keller, Texas 76248.

With this consent, Keller Family Medical Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

I have the right to request that Keller Family Medical Center restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Keller Family Medical Center to use and disclose my protected health information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

I have read and understand the consent for PHI and have been provided a Keller Family Medical Center practice information handout.

Signature:_____Date:_____Relationship to Patient:_____

Print Patient's Name:_____

Print Name of Legal Guardian, if Applicable_____

CONTINUED ON BACK

PHI CONSENT

In order to protect your privacy we have developed a policy on leaving messages or discussing in person your PHI with someone other than yourself:

We will not discuss any medical information with anyone except the patient or legal guardian.
We will not leave any medical information on an answering machine.
We will not leave any medical information on a voice mail system.
We will attempt to, as a courtesy, leave a reminder message regarding an upcoming appointment.

UNLESS

We have your written permission to leave messages for you. Please read the information below and consider carefully whom you want to have access to your medical information, such as test results. Please fill out only **ONE** of the following sections below to make your preferences known.

A. I **DO** consent to leave detailed messages or discuss in person my PHI:

I, _____ give Keller Family Medical Center permission to leave phone messages or discuss my medical care with the following individuals: (Initial each option) This consent will remain in effect until rescinded in writing.

My home phone answering machine number_____ Initials_____

My cell phone voice mail number_____ Initials_____

My spouse (name)_____ Initials_____

Other (name)_____Phone#_____ Initials_____

Signature_____ Date_____

B. I **DO NOT** consent to leave detailed messages or discuss in person my PHI:

I, _____wish to be contacted personally and I do not authorize detailed messages regarding my medical care to be left on an answering machine, cell phone or with others.

Signature_____ Date_____

C. Revocation of prior consent

I, _____ wish to rescind the above authorizations.

Signature_____ Date_____

KELLER FAMILY MEDICAL CENTER
808 KELLER PARKWAY
KELLER, TX 76248

Nurse Practitioner / Physician Assistant
Consent Form

This facility has on staff a Nurse Practitioner and a Physician Assistant to assist in the delivery of quality medical care.

A Nurse Practitioner/ Physician Assistant are not doctors. A Nurse Practitioner and a Physician Assistant are advanced graduates of a certified program and are licensed by the appropriate state board. Under the supervision of a physician, a Nurse Practitioner or a Physician Assistant can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care.
"Supervision" does not require the constant physical presence of the doctor, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A Nurse Practitioner or a Physician Assistant may provide such medical services that are within his or her education, training, and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Offering counseling and education
- Supplying sample medications and writing prescriptions
- Making appropriate referrals

I have read the above, and hereby consent to the services of a Nurse Practitioner or a Physician Assistant for my health care needs.
I understand that at any time I can refuse to see the Nurse Practitioner or Physician Assistant and request to see the physician.

_____. _____.
Name Date

_____.
Signature