PATIENT REGISTRATION FORM

PLEASE PRINT **TODAY'S DATE:** ______________

■ PATIENT'S NAME ____
Last First M.I.

HOME ADDRESS ____

CITY, STATE, ZIP ______________________ GENDER ☐ MALE ☐ FEMALE

RACE: ☐ Asian ☐ Black/African American ☐ White ☐Hispanic or Latino ☐ Other: ____________

ETHNICITY: ☐ Hispanic or Latino ☐ NOT Hispanic or Latino

PREFERRED LANGUAGE: ☐ English ☐ Spanish

BIRTH DATE ______________ MARITAL STATUS ______________

HOME PHONE # ______________ WORK PHONE # ______________

CELL PHONE # ______________ DRIVERS LIC. # ______________

SOCIAL SECURITY # ______________

EMERGENCY CONTACT NAME & PHONE #

PHARMACY PHONE # & ADDRESS ______________________________

(Please include cross streets if address is unknown)
____

San Antonio Family Physicians communicates with our patients through a secure online patient portal. Your email address will be required and will only be used for important communications between you and our staff.

■ **EMAIL ADDRESS** ______________________________

I hereby grant permission to SAN ANTONIO FAMILY PHYSICIANS to perform medical services as deemed necessary by my healthcare provider. I authorize the holder of medical or other information to release any documents required by my insurance carrier, governmental agency, or its intermediary as related to my treatment. I agree to pay any charges incurred by me to San Antonio Family Physicians.

____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: ____________________

ID # ____________________ GROUP # ____________________

ADDRESS: ____________________

SECONDARY INSURANCE NAME: ____________________

ID # ____________________ GROUP # ____________________

ADDRESS: ____________________

PLEASE COMPLETE THIS SECTION IF SOMEONE OTHER THAN THE PATIENT IS THE GUARANTOR ON YOUR INSURANCE PLAN

____

NAME OF GUARANTOR RELATIONSHIP

____

DATE OF BIRTH SOCIAL SECURITY NUMBER

IF THE PATIENT IS A MINOR PLEASE COMPLETE PARENTAL INFORMATION

■ **GUARDIAN'S NAME** ____________________

SOCIAL SEC # ____________________ DOB: ____________________

ADDRESS ____________________

CITY, ST, ZIP ____________________ PRIMARY PHONE # ____________________

Please note: The parent accompanying a child of a divorced family will be responsible for payment of charges incurred for that date of service regardless of insurance or divorce decree status.

ACCIDENT CASE? ☐ *YES* ☐ *NO*

If yes, date of the accident: ____________________

Type of accident? (Brief description) ____________________

____

FINANCIAL POLICY FOR SAN ANTONIO FAMILY PHYSICIANS   ID# ____________

We are committed to providing the best possible medical care and experience to our patients. The intent of this policy is to avoid any misunderstandings or disagreements concerning the prompt payment for our professional services rendered to you.

We want to advise you that should you incur a work related injury or be involved in an automobile accident you will need to seek treatment for these types of injuries from another provider. Our primary care team does not treat these types of injuries.

• FINANCIAL RESPONSIBILITY

The patient/guarantor will accept full responsibility for all services rendered including those deemed to be non-covered by your insurance carrier. It is advisable for you to check with your insurance prior to receiving services by our providers to ensure your treatment will be covered.

• PAYMENT FOR SERVICES

You will be responsible for your copay, co-insurance, and deductibles at time of service. For your convenience, we accept credit cards: [MasterCard, Visa, American Express, Discover] after payment from your insurance carrier is received you will receive a statement for any outstanding balances and your payment will be due within 30 days of the statement date. Currently, we do not charge interest on late payments but we reserve the right to pursue collections of all outstanding balances. In the event that my outstanding debt is sent to collections it will be subject to an additional 25% fee.

• ADDITIONAL FEES that are not covered by insurance

- Copies of Medical Records $25 for the first 20 pages and $.50 for each additional page plus postage. If digital copies are provided fees is $25 for less than 500 pages and $50 for 500 pages or more.
- Disability or other Financial related forms $25 per form (cost is separate from any copay or coinsurance, or deductible for office visit). Patient needs to have an appointment to discuss forms with provider.
- A $35 deposit is required to schedule a new patient, a Saturday and after regular hours (5:00 pm) appointment. The remainder of the deposit will be refunded after applying the visit copay or deductible.
- No Show and No Call fees (first occurrence) $35. No Show and No call fees (second/third occurrence) $50 per occurrence. (These fees will be billed to your account if you do not call to cancel or reschedule your appointment 24 hours in advance. Should you no show 3 visits you will be required to pay a $50.00 deposit for future appointments and we may consider dismissing you from our practice.).
- Requests to the on-call provider to fill prescriptions after hours for routine maintenance medications $25
- There is a $25 administrative process fee charge for personalized letter requests.

• ASSIGNMENT OF BENEFITS

I have read the above financial policy and understand my financial responsibilities to San Antonio Family Physicians. In addition, I authorize **San Antonio Family Physicians** to file insurance claims on my behalf and to accept assignment of benefits for services rendered to me. I give permission to release the necessary medical information as required by my insurance company for payment purposes.

______________________________   ______________________________
Print Patient Name: Date of Birth

______________________________   ______________________________
Signature of Patient   Social Security # (Patient ☐ Guarantor☐)

PRIVACY PRACTICES

- **CONTACTS:** Please list other persons that we may inform about your health information.
Be aware that these people will have full access to your entire medical record.

_______________________________ _______________________________

_______________________________ _______________________________

- **PHONE NUMBERS:** Which phone numbers would you like to receive calls about appointment, financial or medical condition information? ***[Check all that apply]***

☐ Home Phone ☐ Cell phone ☐ Work Phone ☐ Other Phone: _______________________

- **VOICE MAIL:** May financial or medical information such as lab results be left on your answering machine?

☐ Yes ☐ No

- **REMINDERS:** Would you like to receive appointment reminders by

☐ Phone ☐ Text Message ☐ Email

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

As a patient of San Antonio Family Physicians you have been given a copy of our Privacy Practice policy. After reading the policy please sign below your acknowledgement of receipt. Should you have any questions regarding the information in our Notice of Privacy Practices, please speak with our staff and they *will be* happy to address your questions and/or concerns.

I, ____, have received a copy of the **San Antonio Family Physicians Notice of Privacy Practices.** I understand, unless I object in writing, that my health information can be disclosed for any of the outlined reasons given in the Notice of Privacy Practices dated 4/14/2003.

_______________________________ _______________________
Signature of Patient or Legal Guardian Date

_______________________________ _______________________
Please print the name of the patient Patient DOB

E-PRESCRIBING/MEDICATION HISTORY CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

• **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.

• **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

• **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that San Antonio Family Physicians, PA can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to San Antonio Family Physicians, PA to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

______________________________________ ____________________

Signature of Patient or Legal Guardian Date

______________________________________ ____________________

Please print the name of the patient Patient DOB

Patient Medical History

Please provide the following confidential information regarding your medical history. Thank you.

Name: ______________________________ DOB: __________

■ Occupation ______________________________

■ Current medications? ☐ No ☐ Yes **please list:** Name, Dosage, & Frequency

____

____

____

■ **Medical History**. Which medical conditions apply to you? Please provide a brief explanation.

	NO	YES	Explanation
Arthritis	☐	☐	
Asthma	☐	☐	
Bleeding / Blood Disease	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Heart Disease / Murmur	☐	☐	
High Blood Pressure	☐	☐	
High Cholesterol	☐	☐	
Kidney / Urinary	☐	☐	
Liver problems / Hepatitis	☐	☐	
Nervous Disorders	☐	☐	
Seizures or Epilepsy	☐	☐	
Stomach problems	☐	☐	
Thyroid Disorders	☐	☐	
Other	☐	☐	

■ Allergies to medicine? ☐ No ☐ Yes; please list below:

____

■ Previous surgeries? ☐ No ☐Yes; please list: ______________________________

____

____

■ Pregnancy History Number of pregnancies ______________________________

Number of live births ____________ Number of miscarriages/other ________

■ Family History. Which medical conditions apply to your family? Please provide a brief explanation.

	YES	Explanation-Relationship and age at diagnosis
Arthritis	☐	
Asthma	☐	
Bleeding / Blood Disorders	☐	
Cancer	☐	
Diabetes	☐	
Heart Disease / Murmur	☐	
High Blood Pressure	☐	
High Cholesterol	☐	
Kidney / Urinary	☐	
Liver problems / Hepatitis	☐	
Nervous Disorders	☐	
Seizures or Epilepsy	☐	
Stomach problems	☐	
Thyroid Disorders	☐	
Other	☐	

■ Do you use tobacco? ☐ No ☐ Yes How many packs per day?____________

How many years total? ____________

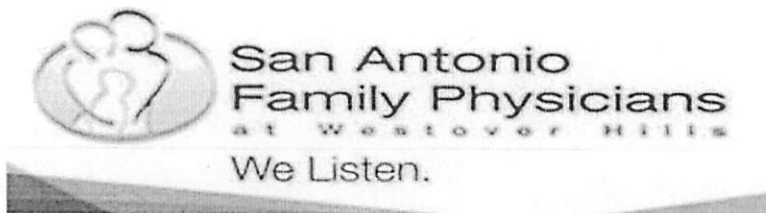
■ Do you drink alcohol? ☐ No ☐ Yes How many drinks a week?____________

■ **Currently,** do you have any of the following symptoms? (Please mark those that apply)

- ☐ Ear/Hearing trouble
- ☐ Visual/Eye trouble
- ☐ Nasal/Sinus trouble
- ☐ Teeth/Gum problems
- ☐ Persistent hoarseness
- ☐ Coughing up blood
- ☐ Difficulty swallowing
- ☐ Frequent cough
- ☐ Pain or lumps in neck
- ☐ Chest Pain/Tightness
- ☐ Racing Heartbeat
- ☐ Shortness of breath
- ☐ Stomach pain
- ☐ Nausea vomiting
- ☐ Heartburn, gas, belching, bloating
- ☐ Poor or excessive appetite
- ☐ Marked weight change
- ☐ Constipation/Diarrhea
- ☐ Rectal pain/bleeding/itch
- ☐ Painful or frequent urination
- ☐ Blood in urine
- ☐ Vaginal discharge/Menstrual problems
- ☐ Breast pain or lumps
- ☐ Take birth control pills
- ☐ Joint pain, swelling, stiffness
- ☐ Muscle pain, weakness
- ☐ Feet/ankle swelling
- ☐ Blackout spells
- ☐ Dizziness
- ☐ Frequent or severe headaches
- ☐ Difficulty sleeping
- ☐ Depression, crying spells
- ☐ Excessive worry
- ☐ Frightening thoughts/dreams
- ☐ Loss of memory/concentration
- ☐ Work or family problems
- ☐ Desire psychiatric help
- ☐ Fever or chills
- ☐ Painful testicles
- ☐ Sexual problems
- ☐ Skin problems/change in mole
- ☐ severe fatigue
- ☐ Numbness/tingling
- ☐ severe fatigue
- ☐ trembling, shaking
- ☐ Use marijuana or hard drugs

I certify that the above information is complete and accurate.

Patient's Signature: ________________________ Date: ____________



ADVANCED FAMILY PRACTICE PROVIDER
CONSENT FOR TREATMENT

San Antonio Family Physicians has Board Certified Advanced Family Practice Providers (APP-AFNP/PA) on staff to assist our physicians in the delivery of medical care.

An Advanced family Practice Provider is not a medical doctor. An AFNP/PA is a registered provider who has received advanced education and training in the provision of health care. An AFNP/PA can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the AFNP/PA may perform various procedures, manage lacerations and other injuries.

I have read the above, and hereby consent to the services of an Advanced Family Practice Provider for my health care needs.

I understand that at any time I can refuse to see the Advanced Family Practice Provider and request to see a physician.

Patient Name: ______________________________ DOB: ________________

Patient Signature: ____________________________ DATE: ________________