PEARLAND HEALTHCARE CENTER
PATIENT REGISTRATION / UPDATE

PATIENT INFORMATION

FIRST NAME:_____M.I._____LAST NAME:_____

S.S.N:_____-_____-_____ DATE OF BIRTH:_____/_____/_____

ADDRESS: _____APT #_____ CITY:_____ST:_____ZIP:_____

CELL PHONE: (_____) _____-_____ HOME PHONE: (_____) _____-_____

SEX: O MALE O FEMALE

MARITAL STATUS: O SINGLE O MARRIED O DIVORCED O WIDOWED

RESPONSIBLE PARTY / POLICY HOLDER

(IF SOMEONE OTHER THAN THE PATENT THIS INFORMATION ALSO NEEDS TO BE FILLED OUT BY PARENT OR GUARDIAN OF ANY CHILDREN UNDER THE AGE OF 18)

FIRST NAME:_____M.I._____LAST NAME:_____

S.S.N:_____-_____-_____ DATE OF BIRTH:_____/_____/_____

ADDRESS: _____APT #_____ CITY:_____ST:_____ZIP:_____

CELL PHONE: (_____) _____-_____ HOME PHONE: (_____) _____-_____

SEX: O MALE O FEMALE

MARITAL STATUS: O SINGLE O MARRIED O DIVORCED O WIDOWED

EMPLOYER: _____

ADDRESS :_____CITY:_____ST:_____ZIP_____

EMERGENCY CONTACT(S)

Please list any person(s) you authorize us to contact in the event of an emergency, or if we are unable to contact you regarding urgent matters pertaining to your health.

NAME:_____ PHONE:(_____) _____-_____ RELATIONSHIP TO PATIENT:_____

DO YOU AUTHORIZE THIS PERSON TO RECEIVE YOUR MEDICAL INFORMATION? O YES O NO

NAME:_____ PHONE:(_____) _____-_____ RELATIONSHIP TO PATIENT:_____

DO YOU AUTHORIZE THIS PERSON TO RECEIVE YOUR MEDICAL INFORMATION? O YES O NO

NAME:_____ PHONE:(_____) _____-_____ RELATIONSHIP TO PATIENT:_____

DO YOU AUTHORIZE THIS PERSON TO RECEIVE YOUR MEDICAL INFORMATION? O YES O NO

*****LABS AND MEDICAL INFORMATION WILL NOT BE GIVEN TO ANYONE NOT INDICATED ON THIS FORM. IT IS THE PATIENT'S RESPOBSIBILITY TO UPDATE THIS INFORMATION SHOULD PREFERENCES CHANGE*****

SIGNATURE: _____ DATE: _____/_____/_____

MEDICAL HISTORY

Patient Name: _____ Date of birth: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○Yes ○No	Excessive Bleeding	○Yes ○No	Liver Disease	○Yes ○No
Alzheimer's Disease	○Yes ○No	Fainting		Low Blood Pressure	○Yes ○No
Anaphylaxis	○Yes ○No	Spells/dizziness	○Yes ○No	Lung Disease	○Yes ○No
Anemia	○Yes ○No	Frequent Cough	○Yes ○No	Osteoporosis	○Yes ○No
Arthritis/Gout	○Yes ○No	Genital Herpes	○Yes ○No	Renal Dialysis	○Yes ○No
Artificial Heart Valve	○Yes ○No	Glaucoma	○Yes ○No	Rheumatic Fever	○Yes ○No
Artificial Joint	○Yes ○No	Hay Fever	○Yes ○No	Rheumatism	○Yes ○No
Asthma	○Yes ○No	Heart attack/Failure	○Yes ○No	Shingles	○Yes ○No
Blood Disease	○Yes ○No	Heart Murmur	○Yes ○No	Sickle Cell Disease	○Yes ○No
Blood Transfusion	○Yes ○No	Heart Pacemaker	○Yes ○No	Sinus Trouble	○Yes ○No
Cancer	○Yes ○No	Heart Disease	○Yes ○No	Stomach/Intestinal	
Chemotherapy	○Yes ○No	Hemophilia	○Yes ○No	Disease	○Yes ○No
Chest Pains	○Yes ○No	Hepatitis A	○Yes ○No	Stroke	○Yes ○No
Cold Sores	○Yes ○No	Hepatitis B or C	○Yes ○No	Swelling of limbs	○Yes ○No
Congenital Heart		Herpes	○Yes ○No	Thyroid Disease	○Yes ○No
Disorder	○Yes ○No	High Blood Pressure	○Yes ○No	Tuberculosis	○Yes ○No
Convulsions	○Yes ○No	High Cholesterol	○Yes ○No	Ulcers	○Yes ○No
Diabetes	○Yes ○No	Hives or Rash	○Yes ○No		
Drug Addiction	○Yes ○No	Hypoglycemia	○Yes ○No	Any serious illness not listed above?	
Emphysema	○Yes ○No	Irregular Heartbeat	○Yes ○No	_____	
Epilepsy or Seizures	○Yes ○No	Kidney Problems	○Yes ○No	_____	

_____

Please List any medications you are currently taking:

_____
_____
_____
_____
_____
_____

Pharmacy Information:

(we send medications excluding controlled substances electronically unless otherwise requested by the patient)

Name: _____

Phone:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in my health/ medical status.

Signature of Patient, Parent, or Guardian:_____ Date: _____

PEARLAND HEALTHCARE CENTER
NOTICE OF PRIVACY POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE ISSUED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

1.) **HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION.** We use health information about you for treatment, to get paid for treatment, for administrative purpose, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, email, fax or other methods. ** we do not email patients any health information** We may use or disclose your health information without your authorization for the reasons listed above. You may also sign an authorization to disclose your health information to a facility, family member, friend etc. please indicate on your patient registration form any person(s) you authorize us to release your information to. Person(s) not listed will not be able to receive your health information. For additional requests you may be asked to sign a release of information in the office and provide proof of identification before information may be released.

2.) **YOUR RIGHTS.** In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we may charge a cost-based fee up to $25 record search fee for pages 1-20 and $0.50 per page for any additional pages. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe that your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information. In addition, you may request that we limit disclosure to your family member, other relatives, caregivers, or close personal friends who may or may not be involved in your care. Pearland Healthcare Center may or may not agree to restrict the use and disclosure of protected health information. If Pearland Healthcare Center agrees to your request, the restriction will be binding on the practice. Use and disclosure of protected health information in violation of an agreed restriction will be a violation of the federal privacy standards.

3.) **OUR LEGAL DUTY.** We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek you acknowledgement of receipt of this notice. We may change our privacy policies at any time. Before we make a significant change in our policies, we will change our notice. The notice will be prominently displayed in our practice. You can also request a copy of our notice at any time. For more information about our privacy policies, contact our office.

4.) **PRIVACY COMPLAINTS.** If you are concerned that we have violated your privacy rights or privacy policies, or if you disagree with a decision we made about access to your health information, you may contact our office. You may also send a written complaint to the U.S. Department of Health and Human Services.

If you have any questions or complaints, please contact
Pearland Healthcare Center
2404 Smith Ranch Rd. Suite 200
Pearland, TX 77584
(713) 436-4333

Acknowledgement of receipt of Notice of Privacy Practices: Please sign and print your name and the date below to acknowledge that you have received the Notice of Privacy Practices.

Patient Name *(print)*:_____ Date: _____/_____/_____
Signature:_____ Relationship to Patient:_____
(of patient or patient legal guardian, POA, etc.)

Financial Responsibility
Acknowledgements and Authorizations

Please read and initial in spaces provided

_____ I hereby authorize Pearland Healthcare Center to furnish my information to my insurance carrier (s) concerning my illnesses and treatments.

_____ I understand that I am responsible for any amount not covered by my insurance.

_____ I acknowledge that my Insurance is not guarantees of payment, all claims are subject to processing, and any amount of payment given to me in the office is merely an estimate

_____ I understand that failure to reconcile any balances owed to Pearland Healthcare Center may result in my account being placed with a collection agency.

_____ I understand that it is my responsibility to update any information regarding my insurance and demographic information. (i.e. home address, telephone numbers, etc.)

_____ I am also aware that all co-pays and deductible portions are due at the time of service and the office **WILL NOT** bill me for my portion of my office visit unless approved by management.

_____ I am aware that the estimated payment amount given to me at the time of my visit is only an estimate and I may be responsible for an additional amount once claims have processed.

I have read and fully understand the Authorizations and Acknowledgements Provided to me by Heights Family Practice DBA Pearland Healthcare Center.

Print Name:_____

Signature:_____

Date: _____/_____/_____