HILLCROFT MEDICAL CLINIC ASSOCIATION

HMC

PATIENT #

CLERK:

PATIENT REGISTRATION IF OTHER THAN RESPONSIBLE PARTY

PLEASE PRINT

YOUR NAME ☐ MR. ☐ MS. ☐ MRS. ☐ MISS FIRST M.I. LAST		YOUR SOCIAL SECURITY #	YOUR DATE OF BIRTH
YOUR MAIL ADDRESS STREET, P.O. BOX, RURAL ROUTE, APT		YOUR HOME PHONE #	YOUR AGE
CITY STATE ZIP		YOUR WORK PHONE # EXT	YOUR SEX ☐ M ☐ F
EMPLOYER	EMPLOYER ADDRESS CITY STATE ZIP		
RACE	ETHNICITY ☐ HISPANIC ☐ NOT HISPANIC	PREFERRED LANGUAGE	

PERSON RESPONSIBLE FOR PAYMENT (GUARANTOR)

PLEASE PRINT

YOUR NAME ☐ MR. ☐ MS. ☐ MRS. ☐ MISS FIRST M.I. LAST		YOUR SOCIAL SECURITY #	YOUR DATE OF BIRTH
YOUR MAIL ADDRESS STREET, P. O. BOX, RURAL ROUTE, APT.		YOUR HOME PHONE #	MARITAL STATUS
CITY STATE ZIP		YOUR WORK PHONE # EXT.	YOUR SEX ☐ M ☐ F
YOUR EMPLOYER		YOUR SPOUSE	
YOUR EMPLOYER'S ADDRESS STREET, P. O. BOX, RURAL ROUTE, SUITE		YOUR SPOUSE EMPLOYER	
CITY STATE ZIP		YOUR DRIVERS LICENSE #	STATE

IN CASE OF EMERGENCY, PLEASE CONTACT NEAREST RELATIVE OR:

NAME ☐ MR. ☐ MS. ☐ MRS. ☐ MISS FIRST M.I. LAST		RELATIONSHIP	DAY TIME PHONE #
ADDRESS STREET, P. O. BOX, RURAL ROUTE, APT.	CITY	STATE	ZIP

REFERRED BY

RELEASE OF RECORDS

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION OBTAINED AND DOCUMENTED BY HILLCROFT MEDICAL CLINIC DURING MY COURSE OF TREATMENT TO MY INSURANCE CARRIER.

SIGNATURE X | DATE

FINANCIAL RESPONSIBILITY STATEMENT

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO HILLCROFT MEDICAL CLINIC. I REALIZE THAT I AM RESPONSIBLE FOR PAYING THE CO-PAYS, DEDUCTIBLE, CO-INSURANCE AND NON-COVERED SERVICES AS DETERMINED BY MY INSURANCE CARRIER. FURTHERMORE, I HEREBY VERIFY THAT I HAVE NO OTHER INSURANCE COVERAGE, PRIMARY OR SECONDARY, OTHER THAN THE CARRIERS LISTED BELOW.

SIGNATURE X | DATE

MEDICAL INSURANCE INFORMATION

PRIMARY CARRIER	VERIFICATION PHONE #	INSURED'S SOC. SEC. #	GROUP NO.
CLAIM MAILING ADDRESS		POLICY NUMBER	EMPLOYER
CITY STATE ZIP		TYPE OF INSURANCE ☐ HMO ☐ MediCare ☐ Workers Comp ☐ PPO ☐ MediCaid ☐ Other	
SECONDARY CARRIER	VERIFICATION PHONE #	INSURED'S NAME	
CLAIM MAILING ADDRESS		POLICY NUMBER	EMPLOYER
CITY STATE ZIP		TYPE OF INSURANCE ☐ HMO ☐ MediCare ☐ Workers Comp ☐ PPO ☐ MediCaid ☐ Other	

Hillcroft Medical Clinic Association

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Hillcroft Medical Clinic Association creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, 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 their Notice and practices and prior to implementation will 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 or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

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

This consent is given freely with the understanding that:

1. Any and all records, whether 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 operations be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

(PATIENT'S NAME PRINTED)	DATE
PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR)	SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)
WITNESS (Optional)	DATE

HILLCROFT MEDICAL CLINIC ASSOCIATION

2500 Fondren
Houston, TX 77063

1429 Hwy. 6 South
Sugar Land, TX 77478

MEDICAL QUESTIONNAIRE

Name			Referred by:	
Address			City/State/Zip	
Home Phone		Office Phone		
Age	Date of Birth	Ht	Wt	Gender: M F
Marital Status: ☐ W ☐ S ☐ D ☐ M		Spouse		

Current Problem (please state in your own words your current medical problem)
How long has it been present?

Allergies: (please list all allergies including both drug and food allergies. If none known please so state)

Medications: (please list ALL medications you are presently taking including birth control pills)

Name of Drug	Dosage	Frequency	Reason

Have you ever taken a Steroid medication? For Example: Cortisone or Prednisone (*A steroid is an anti-inflammatory medicine given for treatment of arthritis or bursitis. It is sometimes injected into painful scars)*

☐ Yes ☐ No Last Date:

Medical/Surgical History:

Surgeries : (please list ALL SURGICAL PROCEDURES, both minor and major)

Date	Hospital	Surgeon	Procedure

Medical Illness: (please list any serious medical illnesses you have had such as problems with your heart, lung, kidneys, intestines or stomach, breast disease, etc.)

Date	Physician Treating	Illness

Have you ever had any of the following illnesses?			
Illness	**No**	**Yes**	**Date**
Yellow Jaundice			
Hepatitis			
Rheumatic Fever			
Heart Murmur			
Pneumonia			
Kidney Stones			
Bladder Infection			
Phlebitis			
Arthritis			
Heart Attack			
Stroke			
Cancer			
High Blood Pressure			
Diabetes			
Other			

General Information			
Do you smoke? ☐ Yes ☐ No		Number of paks a day _____ for _____ years	
Do you drink alcohol? ☐ Yes ☐ No		Indicate level of use: socially moderately heavy	
Is your weight over the year ☐ Up ☐ Down ☐ Stable		_____ pounds.	

Family Medical History **(please list any serious illnesses in members of your immediate family such as Diabetes, Cancer, High Blood Pressure, Breast Diseases, Heart Attacks, Strokes, Lung Problems)**

Relationship	Living or Deceased	Age	Serious Illness or Cause of Death
Mother			
Father			
Grandmother			
Grandfather			
Grandmother			
Grandfather			
Brother			
Sister			

Do you have trouble with any of the following?	YES	NO
Trouble swallowing		
Regurgitation of undigested food		
Heartburn		
Indigestion Foods that cause indigestion frequently:		
Frequent vomiting		
Abdominal pain or cramping Does the pain radiate to your: ☐ Chest ☐ Shoulder blade ☐ Back ☐ Legs		
Diarrhea Times per day		
Constipation		
Back, bloody or *tarry* stools		
Have you had a change in bowel habits		
Have you ever had Pancreatitis		
Have you ever had X-Rays diagnosing the following: ☐ Diverticulosis ☐ Colitis ☐ Ulcers ☐ Cancer		

Do you have trouble with any of the following?	YES	NO
Do you have severe Chest Pain ☐ On exertion ☐ At rest		
Do you have Shortness of Breath		
Do you have Swelling of the Ankles		
Do you have a constant cough producing phlegm		
Do you have a constant dry cough		
Has anyone in your family had lung cancer		
Must you sleep with the hard of your bed elevated		
Have you ever had TB or any other lung disease		
FOR WOMEN ONLY: (Men, please proceed to signature at end of form) Have you ever found a lump in your breast *Date found:* Has it become: ☐ large ☐ smaller Found by: ☐ self ☐ doctor		
Do you have any pain associated with the lump		
Do you have nipple discharge Color ☐ Bloody		
Have you had mammograms taken Date Place		
Have you ever had severe injury to your breast Please explain:		
Is there any history of Breast Cancer in your family		
Is there any history of Fibrocystic Disease in you family		
Date of your last menstrual period (the fist day):		
Have you had a Hysterectomy Date:Ovaries removed? ☐ Yes ☐ No		
Are you taking any Hormones Name of Hormone Dosage Taking for how long		
Number of: Pregnancies _____ Deliveries _____ Miscarriages _____ Number of living children: _____		

PLEASE SIGN THE HISTORY YOU HAVE GIVEN:

_____ DATE

_____ PATIENT SIGNATURE