



PATIENT INFORMATION

Patient's Last Name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Ethnicity: <input type="checkbox"/> Declined <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Unknown	Race (optional): <input type="checkbox"/> Declined <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Unknown		Social Security #		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Primary Language Spoken: _____			Secondary Language: _____				
Street Address:			Home Phone # ()		Cell # ()		
City:	State:	Zip Code:		Email address:			
Occupation:	Employer:			Work Phone # ()			
Referred to clinic by: (please check one box)			<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			

Other family members seen here:

Preferred Pharmacy (Please include name & address)

Local Pharmacy: _____

Mail Order: _____

INSURANCE INFORMATION

<i>Primary Insurance Carrier:</i>	<i>Who is the insured?</i>	<i>Relationship to the Insured:</i>
<i>Member ID #</i>	<i>Group Number:</i>	<i>Birth Date:</i>
<i>Secondary Insurance Carrier:</i>	<i>Who is the insured?</i>	<i>Relationship to the Insured:</i>
<i>Member ID #</i>	<i>Group Number:</i>	<i>Birth Date:</i>

GUARANTOR / RESPONSIBLE PARTY

Name and address:	DOB:	Home Phone:
	SS#:	Work Phone:

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Home Phone:
		Work Phone:

*This information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Wellstone Health Partners** or my insurance company to release any information required to process my claims*

Patient/Guardian Signature _____ **Date:** _____



AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient Name: _____

Address: _____

Date of Birth: _____ Social Security Number: _____

Authorizes **Wellstone Health Partners**, to release the following medical information to:

Name of Person (family member, caregiver, etc.) _____

Address: _____

City/State/Zip _____ Phone Number: _____

Confer orally with person(s) listed below about my medical conditions: (family member, caregiver, etc.)

Name of Person: _____

May we contact you at work and/or leave a message? Yes No

May we contact you at home and/or leave a message regarding appointments? Yes No

This authorization shall be valid from the date of signature. The patient can revoke this authorization in writing at any time.

The patient agrees that a photocopy of this authorization may be considered valid. Yes No

Signature of Patient or Representative _____

Relationship to Patient _____

Date Signed _____

Witness Signature _____



Office Policies

Patient Name: _____ **Date of birth:** _____

As a patient of Wellstone Health Partners I understand that the following policies are currently in effect:

- A \$30.00 fee will be assessed on all returned checks. Returned checks will have to be paid in cash within 10 days of notification. I also understand if outstanding check is not resolved within the 10 day limit I may be dismissed from the practice.
- A \$25.00 may be applied to my account for any missed appointments I do not cancel more than 24 hours in advance. I also understand this fee, if assessed, must be paid prior to my next visit with Wellstone Health Partners.
- I understand payment is due at time services are rendered, unless prior payment arrangements are made with the office. This includes any deductible, copayment or co-insurance amounts. Any balances not paid by my insurance carrier are my responsibility to resolve. I further understand that balances due must be paid in a timely manner to avoid further collection action. I understand if my account is forwarded to a collection agency I may be dismissed from the practice, my outstanding balance may be reported to the credit bureau and my balance may be charged an 18% interest rate per year until balance is resolved.
- **I am to present proof of my insurance coverage at *every* office visit.**
- **I understand if I am more than 15 minutes late for my scheduled appointment I *may* be asked to reschedule for another day.**
- **Finally, I understand that I am to allow at least 48 hours for my prescription refills.**

My signature confirms I have read & understood the above office policies and have had an opportunity to ask questions regarding any concerns I may have about these policies.

Patient Signature

Date



PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Wellstone Health Partners to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of Wellstone Health Partners

I have also been informed of and given the right to review and secure a copy of the clinic's *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Wellstone Health Partners reserves the right to change the terms of this notice from time to time and that I may contact them at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that Wellstone Health Partners is not required to agree to these requested restrictions. However, if they do agree, they are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

Signature of Patient or Representative

Date

Printed Name

Relationship to Patient



PERMISSION TO RELEASE MEDICAL RECORDS

Name:	
Date of Birth:	Social Security #:
FROM:	TO: Wellstone Health Partners
	Dr. _____
	Address _____
	City/State _____
	Phone # _____
	Fax # _____

Release records for the following dates of service: _____

The following information is requested and may be released:		
<input type="checkbox"/> All Records	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Medication Information
<input type="checkbox"/> Medical Summary	<input type="checkbox"/> EKG Reports	<input type="checkbox"/> X-Ray Reports
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Lab Reports	<input type="checkbox"/> Other

<p>I <input type="checkbox"/> do <input type="checkbox"/> do not consent to transmission of my medical records via fax machine.</p> <p>I recognize the information disclosed may contain mental health information that is protected by state and federal laws.</p> <p>I <input type="checkbox"/> do <input type="checkbox"/> do not consent to the disclosure of this information.</p> <p>Signature: _____ Date: _____</p> <p>I recognize the information disclosed may contain drug/alcohol information that is protected by state and federal laws.</p> <p>I <input type="checkbox"/> do <input type="checkbox"/> do not consent to the disclosure of this information.</p> <p>Signature: _____ Date: _____</p> <p>I recognize the information disclosed may contain information regarding sexually transmitted diseases or HIV/Aids testing.</p> <p>I <input type="checkbox"/> do <input type="checkbox"/> do not consent to the disclosure of this information.</p> <p>Signature: _____ Date: _____</p>
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PERMISSION IS HEREBY GRANTED FOR RELEASE OF INFORMATION

Signature of Patient or Representative:	
Relationship to Patient:	Date:



FORMULARY BENEFITS DATA CONSENT FORM

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below, I give permission for **Wellstone Health Partners** to access my pharmacy benefits data electronically through RxHub. This consent will enable **Wellstone Health Partners**:

- Determine the pharmacy benefits and drug copays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medication prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

Patient Name (PRINTED)

Date of Birth

Patient/Guardian Signature

Date



WELLSTONE FAMILY MEDICINE
 800 West Central Texas Expressway, Suite 125
 Harker Heights, TX 76548
 (p) 254.618.1050 (f) 254.618.1058

PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ Date: _____

Parent Name(s): _____

What problem can we help with today? _____

Who is your child's doctor? _____ **No Primary Doctor**

BIRTH HISTORY		
Any mother's health problems during pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any complications with the delivery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was your child born full term?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What was the method of delivery?	<input type="checkbox"/> Vaginal	<input type="checkbox"/> C-section
Did they spend any time in a NICU?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Birth Weight: _____		

PAST MEDICAL HISTORY			
<input type="checkbox"/> No MEDICAL PROBLEMS			
<input type="checkbox"/> Other _____			
Are all of your child's immunizations up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure			
Problem	Type/Comment	Problem	Type/Comment
<input type="checkbox"/> Acid Reflux/GERD		<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Anemia		<input type="checkbox"/> Hayfever (Allergies)	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Head Injury	
<input type="checkbox"/> Bleeding Disorder		<input type="checkbox"/> Migraines	
<input type="checkbox"/> Cancer		<input type="checkbox"/> Sleep Apnea	

PAST SURGICAL HISTORY		
<input type="checkbox"/> No PREVIOUS SURGERIES		
Year	Type	Hospital

*Additional sheet for listing surgeries available at the front desk

FAMILY HISTORY

<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Other:
<input type="checkbox"/> Cancer: _____	<input type="checkbox"/> Migraines	

PRESCRIBED DRUGS, OVER-THE-COUNTER DRUGS, HERBALS, AND SUPPLEMENTS

Medication Name	Strength	Frequency Taken

*Additional sheet for listing medications and/or allergies available at the front desk

MEDICATION AND FOOD ALLERGIES

<input type="checkbox"/> No Medication Allergies		<input type="checkbox"/> Latex Allergy		<input type="checkbox"/> Iodine (Shellfish) Allergy	
Medication/Food	Type of Reaction	Medication/Food	Type of Reaction		

SOCIAL HISTORY

Occupation	What grade is your child in? _____	Do they listen to loud music? <input type="checkbox"/> Yes <input type="checkbox"/> No
Other	Is your child exposed to tobacco smoke (secondhand)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pets	Are there pets in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what types? <input type="checkbox"/> Dogs <input type="checkbox"/> Cats <input type="checkbox"/> Birds <input type="checkbox"/> Reptiles (lizards, turtles, etc) <input type="checkbox"/> Other: _____	

CURRENT SYMPTOMS (PLEASE CIRCLE) OR NO SYMPTOMS

Constitutional/General	Respiratory	Indigestion	Endocrine
Fever	Cough	Genitourinary	Excessive Thirst
Weight Loss	Shortness of Breath at Rest	Blood in Urine	Psychological
Loss of Appetite	Shortness of Breath-Exercise	Urinating Frequently	Anxiety
Ear, Nose, Mouth, Throat	Sputum	Skin	Depression
Stuffy Nose	Wheezing	Rash	Hematological/Lymphatic
Runny Nose	Gastrointestinal	Itching	Easy Bleeding
Sore Throat	Vomiting	Neurological	Easy Bruising
Ear Pain	Diarrhea	Seizures	Lymph Node Enlargement
Cardiovascular	Constipation	Headaches	Ice Chewing
Chest Pain	Blood in Stools	Musculoskeletal	Allergic/Immunological
Fainting	Black Stools	Joint Pain	Allergic Dermatitis
	Abdominal Pain	Joint Swelling	Frequent Illnesses

Office Use Only

Reviewed by MD: _____ Date: _____