Conroe Willis Family Medicine

PATIENT PROFILE

PATIENT INFORMATION

Patient Name: _____ Gender: _____
Address: _____ Date of Birth: _____
City, Zip: _____ Social Security #: _____
Home Phone: _____ Marital Status: _____
Work Phone: _____ Cell Phone: _____
Email: _____ Referring Physician: _____

HOW DID YOU HEAR ABOUT US?

Patient__ Social Media__ Website__
Newspaper__ Magazine__ Family/Friend__
Internet__ Physical Referral__ Other__

RESPONSIBLE PARTY (Must complete if responsible party is other than the insured or patient.)

☐ Same as Patient ☐ Same as Insured Relation to Patient: _____
Name: _____ Employer: _____
Address: _____ Phone: _____
City, State & Zip: _____ Date of Birth: _____
Social Security #: _____

PRIMARY INSURANCE (Must be completed in its entirety in order for us to file with your insurance.)

Name of Insured: _____ Relation to Patient: _____
Name of Insurance Company: _____ Insured ID #: _____
Insurance Phone #: _____ Policy Group #: _____
Insured Employer: _____ Insured Date of Birth: _____

IS THE PATIENT COVERED UNDER ANY OTHER INSURANCE? YES or NO
(If YES, please complete secondary insurance below.)

SECONDARY INSURANCE (if applicable.)

Name of Insured: _____ Relation to Patient: _____
Name of Insurance Company: _____ Insured ID#: _____
Insurance Phone #: _____ Policy Group #: _____
Insured Employer: _____ Insured Dated of Birth: _____

I understand that this form must be completed in its entirety. I understand that if all of the above information is not completed, a claim may not be able to be filed to my insurance company; therefore, making me fully responsible for any charges incurred.

Patient/Responsible Party Signature: _____ **Date:** _____

Conroe Willis Family Medicine

CONDITIONS OF SERVICE

PATIENT: _____ DOB: _____ ACCT #: _____

Assignment of Benefits and Release of Patient Healthcare Information

I hereby authorize Conroe Willis Family Medicine to release patient healthcare information, complied from the medical records pertaining to my services, in accordance with the policy of the clinic and Texas law, to facilitate reimbursement by a health benefit plan or third party payer, including but not limited to, my insurance carrier, Medicare, Medicaid, and any other payer or agency. I also hereby authorize payment of insurance benefits under the terms of my policy directly to Conroe Willis Family Medicine (CWFM) for services rendered. I am financially responsible and will pay for charges not covered by my insurance plan.

Financial Agreement and Statement of Responsibility

For and in consideration of services rendered or to be rendered by Conroe Willis Family Medicine (CWFM), I agree to pay said clinic for all services and charges. I understand that I am responsible for any health insurance deductibles, coinsurance and non-covered charges. Payment in full is due at time of services are rendered or payment arrangements are to be made before your appointment.

X_____ _____

Patient/Guarantor Signature Date

Consent to Medical Treatment by Physician

I, or authorized representative/legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services, which may include routine diagnostic procedures and such medical treatment as the physician, his/her assistants or his/her designees consider to be necessary in his/her judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to results of treatment or examination at Conroe Willis Family Medicine (CWFM).

X_____ _____

Patient/Guarantor Signature Date

Consent to Medical Treatment by Physician Assistant

I, or authorized representative/legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services from a physician assistant. I fully understand that a physician assistant IS NOT A PHYSICIAN. I further acknowledge that the general medical services provided to me by a physician assistant are the responsibility of the physician providing the services at Conroe Willis Family Medicine (CWFM) both professionally and legally, for acts of such allied health personnel rendered during the care and treatment of his/her patients.

X_____ _____

Patient/Guarantor Signature Date

Release of Patient Healthcare Information

I, or authorized representative/legal guardian acting on behalf of the patient, hereby authorize Conroe Willis Family Medicine (CWFM) to release patient healthcare information, in accordance with the policy of the clinic, as is necessary to healthcare providers to facilitate reimbursement by a health benefit plan or personnel of another healthcare entity for the sole purpose of providing current continuum of care including, but not limited to fax, mail or electronic submission.

X_____ _____

Patient/Guarantor Signature Date

Do you have an advanced directive (living will)? ___ Yes ____ No

If yes, please bring a copy into our office for our files.

If no, and you would like information on an advanced directive, please speak with your physician.

Conroe Willis Family Medicine

Acknowledgement of Review of Privacy Practices

I, the undersigned, have reviewed the Conroe Willis Family Medicine (CWFM) Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of the Privacy Practices.

Signature of Patient or Representative

Date

Printed Name of Patient or Personal Representative

Capacity of Personal Representative
(Parent, Guardian, Trustee, Executor)

Address

City, State, Zip Code

Conroe Willis Family Medicine

Health Questionnaire

NAME: _____ DOB: _____

Please fill out the following form in order for us to understand your healthcare needs.

What is the reason for your visit to the clinic today?

_____

Past Medical History

_____ Diabetes
_____ Liver Disease
_____ Kidney Disease
_____ High Cholesterol
_____ Irregular Heartbeat
_____ Heart Attack
_____ Coronary Artery Disease
_____ Emphysema
_____ Asthma
_____ High Blood Pressure
_____ Mental Illness
_____ Tuberculosis
_____ Cancer
_____ Strokes
_____ Seizures
_____ Excessive Bleeding
_____ Reflux/Ulcers
_____ Glaucoma
_____ Thyroid Problems
_____ Joint Disease

Other: _____

Pharmacy Name: _____ Pharmacy Phone #_____ Pharmacy City: _____

Please list all current medications with dosage:_____

_____

_____

_____

Are you allergic to any medications? _____Yes _____ No

If **YES**, please list: _____

_____

Past Surgeries: _____

_____

_____

_____

Social History

Do you drink? _____ Yes ____ No If YES, how much? _____

Do you smoke? _____ Yes ____ No If YES, how much? _____

Marital Status: _____ What is your occupation? _____

Race: ____ American Indian or Alaska Native _____ Native Hawaiian or Other Pacific Islander
____ Asian _____ White
____ Black or African American _____ Unknown _____ Patient Declined

Ethnicity: _____ Hispanic or Latino _____ Not Hispanic or Latino _____ Unknown _____ Patient Declined

Preferred Language: _____ English _____ Chinese (Cantonese) _____ Russian _____ Portuguese
_____ Spanish _____ Chinese (Mandarin) _____ Japanese _____ Unknown
_____ French _____ German _____ Italian _____ Patient Declined

Conroe Willis Family Medicine

Health Questionnaire, Continued

NAME: _____ DOB: _____

Family History

Do any of your family members have the following?
If YES, please list who and their age:

Disease	Family Member	Age
Anemia		
Asthma		
Bleeding Disorder		
High Blood Pressure		
High Cholesterol		
Strokes		
Seizure		
Heart Attack		
Liver Disease		
Diabetes		
Thyroid Disease		
Kidney Disease		
Mental Illness		
Joint Disease		
Cancer (Type)		

Preventive Medicine

When was your last:

Mammogram _____
Pap Smear _____
Bone Density _____
Colonoscopy _____
Rectal Exam _____
PSA _____
Flu Vaccine _____
Pneumovax _____
Tetanus Shot _____
TB Skin Test _____

Name: _____

DOB: _____

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO DESIGNATED REPRESENTATIVE(S)

I, _____, give my authorization to release my protected health information including results of my laboratory test, x-ray and/or other test results to the following designated representative(s).

Patient initials	
_____	My spouse (Name) _____
_____	My child (Name) _____
_____	Other (Name) _____
_____	Personal Representative _____
_____	May be left on my answering machine at home
_____	May be left on my answering machine at work
_____	May be left on my cell phone _____
_____	MAY NOT BE GIVEN TO ANYONE OTHER THAN MYSELF

_____ _____

Patient Signature Date

_____ _____

Witness Date

As a patient, you have the right to revoke this authorization in writing at any time, except to the extent action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Conroe Willis Family Medicine must receive the revocation in writing. The revocation must include 1) the patient's name, address, and date of birth 2) the patient's desire to revoke the authorization and 3) the date of the revocation and the patient's signature. All revocations must be sent in writing to the attention of: Director of Operations at 4015 I-45 N., Suite 220 Conroe, TX 77304 or faxed to 936-441-4440 and will not be considered effective until received by this office.

Conroe Willis Family Medicine

Jason Laningham, M.D., Jeremy Laningham, M.D.
Joshua Dubose, M.S. PA-C, Sydney Payne, PA-C, Gwen Dubose, PA-C, Patricia Green RN FNP, Carol Leibold RN FNP

Authorization To Inspect and Release Protected Health Information

Please send records to: 804 W. Montgomery Willis, TX 77378 Fax: 936-890-9000
4015 I-45 North, Suite 220 Conroe, TX 77304 Fax: 936-494-4440

Patient Name: _____

Address: _____

SSN: _____ **DOB:** _____

Phone Number: _____

I hereby authorize **(Please include doctor of facility name, phone number and address)**:

_____

_____

_____

To RELEASE medical records to: **Conroe Willis Family Medicine**

The following health information to be disclosed is maintained in the designed record set:

_____ Complete Medical Records _____ History & Physical _____ Progress Notes
_____ Pathology Reports _____ Radiology Reports _____ Discharge Summaries
_____ Consult Reports _____ Report of Procedures _____ Laboratory Tests
_____ Other: _____

For the purpose of continue medical treatment.

I understand that this information may include information to specific laboratory test of HIV or the diagnosis of Acquired Immune Deficiency (AIDS) or AIDs-related conditions; treatment for drug or alcohol abuse; mental or behavior health or psychiatric care, excluding psychotherapy notes.

This Authorization is given freely with the understanding that: I may revoke the authorization at any time in writing, unless the information has already been released.

Signature, Patient or Legal Guardian: _____ **Date:** _____
Name and Relationship: _____

Conroe: 4015 I 45 N, Suite 220 Conroe, TX 77304 Phone: 936-441-1122 Fax: 936-494-4440
Willis: 804 W. Montgomery St. Willis, TX 77378 Phone: 936-890-8000 Fax: 936-890-9000