TEXAS REGIONAL CLINIC
www.TexasRegionalClinic.com

Scheduling Direct Line: (713)489-1741
Fax: (713)984-8481
Email: Referral@TexasRegionalClinic.com
8301 Katy Freeway | Ste 101 | Houston, Texas

REGISTRATION FORM

PATIENT INFORMATION							
Patient Name:					Date:		
DOB:				SEX	Male: ☐	Female ☐	
MARITAL STATUS	Married ☐	Single ☐	Widowed ☐	Divorced ☐			
LANGUAGES SPOKEN	1.		2.				

PATIENT CONTACT INFORMATION			
Home Phone:	Cell Phone:	Pager No.:	
Mailing Address:	City:	State:	Zip:
Email Address:			
Spouse Name:			
Spouse Social Security No.	Spouse DOB:		

EMERGENCY CONTACT INFORMATION *(Not Living in The Same Household)*			
Contact Name:			
Contact Phone No.:	Relationship:		

PATIENT EMPLOYMENT INFORMATION			
Patient's Employer	Work No.:		
Employer's Address	City:	State:	Zip:

HEALTH INSURANCE INFORMATION		
Insurance Provider:	Policy #:	Group #:
Subscribe Name:	Subscriber DOB:	
Subscriber SSN: _____-_____-_____	Relationship to Subscriber:	

PATIENT'S PRIMARY CARE PHYSICIAN			
Physician Name:	Work No.:	Fax No.:	
Clinical Address:	City:	State:	Zip:

PATIENT'S REFERRING PHYSICIAN			
Physician Name:	Work No.:	Fax No.:	
Clinical Address:	City:	State:	Zip:

PREFERRED PHARMACY			
Pharmacy:	Contact No.:	Fax No.:	
Address:	City:	State:	Zip:

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REASON FOR VISIT

Details:

MEDICAL HISTORY

☐ Anemia	☐ Anesthesia Complications	☐ Angina	☐ Aortic Aneurysm
☐ Asthma	☐ Atrial Fibrillation	☐ Blood Clots/DVT/Pulmonary Embolism	☐ Bowel Obstruction
☐ Breast Cancer	☐ Cerebrovascular Accident (Stroke)	☐ Cervical Cancer	☐ COPD
☐ Cirrhosis	☐ Colitis	☐ Colon Cancer	☐ Congestive Heart Failure
☐ Coronary Artery Disease	☐ Dementia	☐ Depression	☐ Diabetes
☐ Diverticulitis	☐ GI Bleed - Lower	☐ Gastric (Stomach) cancer	☐ H. Pylori Infection
☐ HIV/AIDS	☐ Heart Attack (MI)	☐ Heart Murmur	☐ Hepatitis
☐ Hypercholesterolemia	☐ Hypertension	☐ Hyperthyroidism	☐ Hypothyroidism
☐ Low platelets	☐ Lupus	☐ Mitral Valve Prolapse	☐ Multiple Sclerosis
☐ Osteoarthritis	☐ Ovarian Cancer	☐ Peripheral Arterial Disease	☐ Pregnant/Planning?
☐ Prostate Cancer	☐ Prostate Enlarged	☐ Pulmonary Embolism	☐ Reflux/GERD (heartburn)
☐ Rheumatoid Arthritis	☐ Seizure/Epilepsy	☐ Skin Cancer	☐ Sleep Apnea
☐ Stomach Ulcers	☐ Thyroid Cancer	☐ Ulcerative Colitis	☐ Other:

SURGICAL HISTORY

1. _____ DATE OF SURGERY: _____
2. _____ DATE OF SURGERY: _____
3. _____ DATE OF SURGERY: _____
4. _____ DATE OF SURGERY: _____
5. _____ DATE OF SURGERY: _____

Additional Notes:

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REGISTRATION FORM

MEDICATIONS *(Medications you're currently taking)*

1. _____ Dosage: _____ How is it taken? _____
2. _____ Dosage: _____ How is it taken? _____
3. _____ Dosage: _____ How is it taken? _____
4. _____ Dosage: _____ How is it taken? _____
5. _____ Dosage: _____ How is it taken? _____

ALLERGIES

Non-medication allergies:

Medication allergies:

SOCIAL HISTORY

Working ☐	Student ☐	Unemployed ☐	Disabled ☐	Retired ☐

Do you use tobacco products?	☐ No	☐ Yes	If yes, type/amount/how long:
Do you drink alcohol?	☐ No	☐ Yes	If yes, type/amount/how long:
Do you use illicit drugs?	☐ No	☐ Yes	If yes, type/amount/how long:

FAMILY HISTORY *(History of Medical Ailments)*

Parents:

Siblings:

Other:

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REGISTRATION FORM

PATIENT INFORMATION					
Patient Name:					
DOB:	Date:	SEX	Male: ☐	Female: ☐	Age:
Phone No.:		Social Security No.:			
Address:	City:		State:	Zip:	

AUTHORIZATION FOR TREATMENT

I hereby consent to treatment by the attending physician and other medical staff for all local anesthetics, test, surgical and other medical procedures as deemed necessary by myself and the medical staff.

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby assign to the above-named office, those benefits otherwise payable to me by any third party as reimbursement of expenses and fees in connection with treatment rendered. I request that payment of authorized benefits be made directly to the medical provider named above on my behalf.

I FULLY UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL AMOUNTS NOT OTHERWISE PAID BY MY INSURANCE CARRIER.

I certify that the information about me to be released to the Health Care Finance Administration or other health care coverage entity, any information needed for this or any related health care claim in writing or verbally. I further understand and agree to pay for services or amounts due when appropriate. These charges could include amounts applied to my annual deductible co-payment amounts, and charges denied as not covered by my insurance program or deemed medically unnecessary. I understand that well care is not covered by Medicare or many other health insurance programs.

I hereby authorize release of my films and/or medical records as needed for subsequent medical care. In the event of positive findings, I authorize my attending physician to release the results of my biopsy-surgery to my referring physician named above for their records.

If someone other than the patient is signing this authorization, please state relationship with patient and the reason patient is unable to sign.

Information reviewed and verified on: _____
(Today's Date)

By: _____
(Patient Signature)

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HIPAA Authorization and Notice of Receipt of Privacy Practices

PATIENT INFORMATION					
Patient Name:			MRN:		
DOB:	Date:	SEX	Male: ☐	Female: ☐	Age:

I have been provided access to Texas Regional Clinic Notice of Privacy Practices. I understand that I am entitled to a copy of these practices at my request.
I furthermore acknowledge that I have the right to designate access to my Protected Health Information (PHI) to anyone of my choosing. I hereby authorize disclosure of my PHI to the following individual(s).

Authorized Individuals:

1. _____

2. _____

3. _____

I request the following restrictions to releasing my PHI:

1. _____

2. _____

3. _____

I understand I may revoke this authorization at any time by submitting a written request to Texas Regional Clinic Privacy Officer, as per the office's Notice of Privacy Practices.
I understand that by signing this authorization, this information will be used by Texas Regional Clinic to make determinations for the release of my PHI. I also understand this authorization will remain in effect until I request an update and/or amendment.

Information reviewed and verified on: _____
(Today's Date)

By: _____
(Patient Signature)

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NOTICE OF PRIVACY PRACTICES

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

Protecting Your Privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the internet. At Texas Regional Clinic (hereinafter referred to as "the Practice"), privacy is one of our highest priorities.

Keeping Your Information

Keeping the medical and health information we have about you secure, is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary, to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

Working to Meet Your Needs Through Information

In the course of doing business, we collect and use various types of information, like name and address and claims information. We use this information to provide services to you, to process your claims and to bring your health information that might be of interest to you.

Keeping Information Accurate

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please call or write us at the telephone numbers or addresses listed below. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

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How and Why Information Is Shared

We limit who receives information and what type of information is shared.

Sharing information within the Practice. We share information within our company to deliver you the healthcare services and the related information and education programs specified in your plan.
Sharing information with companies that work for us. To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies and companies that deliver health education and information directly to you. These companies act on our behalf and are obliged contractually to keep the information that we provide them confidential.
Other Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.
If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies. The Practice does not share any customer information with third party marketers who offer their products and services to our patients.

Count on Our Commitment to Your Privacy

You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us- whether it's at our office, over the phone or through the Internet.
If you have questions regarding your privacy rights, please call Texas Regional Clinic at 713-554-3207. If you believe your privacy rights have been violated, you may file a complaint by contacting Texas Regional Clinic at 713-554-3207 or with the U.S. Department of Health and Human Services.

You will not be penalized for filing a complaint. The address for the U.S. Department of Health and Human Services is:

Office For Civil Rights

US Department of Health and Human
Services Atlanta Federal Center

Suite 3870
61 Forsyth St., SW
Atlanta, Georgia 30303-8909
(404)562-7886 (phone)
(404)562-7881 (fax)
(404)331-2867 (TDD)
www.hhs.gov/ocr/hipaa

Information reviewed and verified on: _____
(Today's Date)

By: _____
(Patient Signature)