TOTAL FAMILY CARE

NEW PATIENT REGISTRATION FORM

ALIEF ISD? (please circle one) YES / NO	**PCP:**
How did you hear about us?	

PATIENT INFORMATION

Patient's last name	**First**	**M.I**	**Date of Birth** / /

Would you like access to our Patient Portal? (if so, we need your email) ❑ Yes ❑ No ***Email address for your portal:***	Marital Status ❑Single ❑Married ❑Separated ❑ Widowed	Preferred way of communication ❑Phone call ❑Text message ❑Email ❑Patient Portal	Sex ❑ M ❑ F

Street address:	**Social Security number:** - -

City	**State**	**Zip code**	**Phone number** - -

Race American Indian / Asian / African American / White / Other Race	**Ethnicity** Hispanic/Latino / Not Hispanic or Latino

Pharmacy name: _____

Phone number: _____

Pharmacy city and/or zip code: _____

INSURANCE INFORMATION

(Please give your insurance card & ID to the receptionist.)

❑ Multiplan ❑Medicare ❑ Aetna ❑ Blue Cross Blue Shield ❑ Cigna ❑ Humana ❑ United Health Care

Subscriber's name:	Birth date: / /	Member ID #	PCP:	Co-payment: $

IN CASE OF EMERGENCY

Contact:	Relationship:	Phone:	Email:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature **Date**

AUTHORIZATION – NON-PARENT/GUARDIAN TO ACCOMPANY PATIENT (MINOR)

❑ *NO ONE OTHER THAN THE PARENT(S) IS ABLE TO BRING MY CHILD(REN) TO THE CLINIC.*

Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances; however, we must have a written authorization letter allowing this person to accompany your child(ren). The person bringing your child will need to present photo identification at time of service.

This authorization gives the person permission to bring your child(ren) in, speak to the doctor, given authorization for treatment, vaccinations, medication, and certain procedures and make general health decisions.

I, _____, give the person(s) listed below permission to bring my child to Total Family Care and to discuss and share medical information about my child. I further authorize them to see all necessary medical records and make health care decisions of a routine nature as determined at the sole discretion of the provider.

I also give them authority to make more serious or urgent health care decisions in the event that I cannot be reached or where it is of an emergency nature where there is not sufficient time to seek of my specific consent.

Child's name: _____ DOB: _____
Child's name: _____ DOB: _____
Child's name: _____ DOB: _____

Limitations(if any): _____
_____
_____

Name of person authorized: _____ Relationship: _____
Name of person authorized: _____ Relationship: _____
Name of person authorized: _____ Relationship: _____

_____

Parent/Guardian Signature Date

TOTAL FAMILY CARE

NEW PATIENT HEALTH HISTORY

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME: ☐ M ☐ F	**DATE:**
DOB:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

CHILDHOOD ILLNESS: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

☐ Diabetes	☐ Kidney Disease	☐ Depression
☐ High Cholesterol	☐ Bladder Problems	☐ Anxiety
☐ Thyroid Disease	☐ Prostate Problems	☐ Psychiatric
☐ High Blood Pressure	☐ Asthma	☐ Arthritis
☐ Heart Attack	☐ Chronic Bronchitis	☐ Osteoporosis
☐ Angina/Chest Pain	☐ Emphysema	☐ Gout
☐ Congestive Heart Failure	☐ Allergies	☐ Back Problems
☐ Other Heart Disease	☐ Pneumonia	☐ Eye Problems
☐ Other Lung Disease	☐ Ear Problems	☐ Hiatal Hernia
☐ Bleeding/Clotting Disorder	☐ Stroke	☐ Liver Disease
☐ Seizures/Epilepsy	☐ Stomach Ulcers	☐ Anemia
☐ Disease of the Colon	☐ Hemorrhoids	☐ Head Injury
☐ Accidents/Broken Bones	☐ Cancer _____	☐ Other _____

PLEASE LIST ANY FAMILY HISTORY BELOW

SURGERIES

Year	Reason	Hospital

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING VITAMINS AND/OR HERBAL SUPPLEMENTS/REMEDIES

Name	Dose/Strength	Frequency Taken

LIST ANY ALLERGIES TO MEDICATIONS, FOOD, OR LATEX	
Name the Drug	Reaction

Exercise	☐ No				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you currently dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	_____ cups/cans per day?				
Alcohol/ Tobacco	Do you drink alcohol?			☐ Yes	☐ No
	How many drinks per week? _____				
	Do you smoke tobacco?		_____ packs/day	_____ years	Want to stop? _____

PLEASE USE THIS SPACE TO INDICATE ANY OTHER HEALTH HISTORY THAT THE PHYSICIAN SHOULD KNOW ABOUT. THANK YOU.