Patient Information: **(Please fill out every field completely. Circle Items in blue)**

First Name and M.I.		I II III IV V	Other:
Last Name		Jr Sr	
Mailing Address		Date of Birth:	
Address line 2			
City, State		Phone Number:	
Zip code			
Sex: M F		Relationship to patient:	
Email Address		Self Parent Spouse Guardian	

(Disregard Insurance fields if you submitted an insurance card in person or via email to regina.boa@hallsvillemedicalclinic.com and you are the main subscriber on your insurance)

Insurance Name:	Insurance Phone:
Subscriber name:	Subscriber DOB:
Member ID:	
Group Name/Employer:	Group ID Number:
Relationship to Subscriber: Self Spouse Child Other:	

Reason for Visit:
How did you hear about us?
Facebook Friend Family Website Google Instagram Billboard Signage around town

I authorize release of my information in the event of an emergency to the following person: (If none, leave blank)

Emergency Contact Name:	
Emergency Contact Phone:	
Any Restrictions:	
Relationship:	

YES or NO You may leave confidential clinical information on my answering machine/voicemail.

Signature*: _____ DATE: _____

Printed Name: _____Relationship to Patient _____

**If the patient is unable to sign this agreement or is a minor, I am entering into the agreement on behalf of and as the legally authorized representative of the patient. The appropriate paperwork has been given by the patient to the Clinic.*

HIPPA PROTECTED HEALTH INFORMATION – ACCESS FORM

I understand that stated and federal laws permit HALLSVILLE MEDICAL CLINIC to share Protected Health Information), with the persons involved in my care or the payment of my health care services. I further understand that I have (i) the right to grant certain persons access to my PHI and (ii) the opportunity to restrict access to my PHI from certain persons who might otherwise have access. I understand that granting access DOES NOT give the person access to copies of my medical records. I grant permission for the following persons to have access to my Protected Health Information.

NAMES (please print)	DOB	Phone Number

I understand that I may change or revoke this form at any time by contacting the Health Information Management Department (directly forwarded to the Business Office Administrator) at the Hallsville Medical Clinic office location. I understand that such changes or revocation will not be effective for disclosures that have already been made or access which has already occurred based on this form.

CONSENTS AND AGREEMENTS

I understand that the following packets of paperwork were made available to me to review before and at my initial new patient visit. my signature below indicates my authorization of these policies regarding my medical treatment. I can request a copy of any/all these documents at any time, and I am aware they are available for review on www.hallsvillemedicalclinic.com

PATIENT CONSENT, PATIENT AUTHORIZATION, FINANCIAL, CLINIC CARE CONSENT
(Requests for these documents can be made by email to hmc@hallsvillemedicalclinic.com or in person)

ACKNOWLEDGEMENT: By signing below, I certify that I have read this document, understand its contents, and agree to the terms. I acknowledge that I am the patient, or I am the patient's legally authorized representative and/or Guarantor. A photocopy or a faxed copy of this consent shall be deemed as valid as the original.

Signature*: _____ DATE: _____

Printed Name: _____Relationship to Patient _____

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MEDICAL HISTORY

(Please fill out in entirety- if you have questions, you can ask the MA, or PA-C)

Marital Status: *(Circle)* Single Partnered Married Separated Divorced Widowed		Occupation:
Previous/Referring Doctor:	Date of last Physical:	/ /

Medications: Please bring all prescription medications you are currently taking
(A physical list is also an acceptable substitute, or bring your medications in for the front staff)

Name	Dose/Directions/Reason	Name	Dose/Directions/Reason

Allergies	Reactions

Do you currently have, or have ever had, any of the following illnesses or conditions?

- ☐ **Anemia**
- ☐ **Abnormal Pap**
- ☐ **Anxiety/Depression**
- ☐ **Arthritis**
- ☐ **Asthma**
- ☐ **Atrial Fibrillation**
- ☐ **Blood Clots**
- ☐ **Cancer**
- ☐ **Chronic Lung Disease**
- ☐ **Colon/Bowel Disease**
- ☐ **Diverticulites**
- ☐ **Dementia**
- ☐ **Diabetes**
- ☐ **Gallbladder Disease**
- ☐ **Alcohol/Drug use**
- ☐ **Emphysema**
- ☐ **Heart Attack**
- ☐ **Glaucoma**
- ☐ **Head injury**
- ☐ **Gout**
- ☐ **Hay Fever**
- ☐ **Heart Disease**
- ☐ **Hepatitis**
- ☐ **Liver Disease**
- ☐ **Hernia**
- ☐ **High Blood Pressure**
- ☐ **High Cholesterol**
- ☐ **Heart Murmur**
- ☐ **Infection of the uterus**
- ☐ **Kidney Disease**
- ☐ **Migraines**
- ☐ **Neuropathy**
- ☐ **Osteoporosis**
- ☐ **Other injuries**
- ☐ **Peripheral Artery Disease**
- ☐ **Pneumonia**
- ☐ **Positive TB test**
- ☐ **Prostate problem**
- ☐ **Psychiatric – Depression**
- ☐ **Psychiatric – Other**
- ☐ **Rheumatic Fever**
- ☐ **Seizures**
- ☐ **Sexually Transmitted Disease**
- ☐ **Sleep Apnea**
- ☐ **Stroke**
- ☐ **Thyroid Disease**
- ☐ **Tuberculosis**
- ☐ **Ulcer**

Surgical and Hospitalization History	**Dates**

Immunizations	Date	Immunization	Date		Date
Flu Vaccine		Zostavax (Shingles) Shinglex (Shingles)		Pneumococcal PPV23	
TDAP (Whooping cough/tetanus)		HPV		Hepatitis A	
Pneumococcal		Meningococcal ACWY		Hepatitis B	

PCV13					
Covid-19 (*type):*		Meningococcal B		TD (tetanus shot)	

Previous Physician's Name		Specialty	

List date last performed, result if applicable under each test

Aortic Aneurysm Screen	Cholesterol Test	Colonoscopy	Dental Exam
Eye Exam	Hepatitis C Test	HIV Test	HPV Test
Mammogram	Pap Smear	Prostate Exam	Stool Test for Blood

Family History (use back of page if needed) Please circle items in blue		**Age**	**Medical Conditions** Indicate Healthy or diabetes, high blood pressure, cholesterol, heart disease, stroke, cancer (type)
Mother	Living or Deceased		
Father	Living or Deceased		
Grandmother (Mother's side)	Living or Deceased		
Grandfather (Mother's side)	Living or Deceased		
Grandmother (Father's side)	Living or Deceased		
Grandfather (Father's side)	Living or Deceased		
Other Family	Cancer Heart Attacks Stroke Diabetes		

Smoking	Cigarette Use: Never Former Smoker Current Smoker Other tobacco use (*please circle*): Pipe, Cigars, Chewing Tabaco Other: E-Cigarettes, Marijuana Date or Age quit: _____	
Alcohol	Do you drink Alcohol? YES or NO Frequency per month: Frequency per Week:	Each week, how many: _____ Servings of beer? _____ Glasses of wine? _____
Drugs	Have you used recreational or street drugs within the last two years? Yes or No Have you ever used recreational drugs with a needle? Yes or No	
Sexual Health	Sexually Active: Yes or No	Sexual Partners: Male Female
	# of children_____# of pregnancies____# of miscarriages____# of abortions____ Date of last menstrual period (start date): _____/_____/_____	
Women:		

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION I HAVE GIVEN ABOVE IS ACCURATE, COMPLETE, AND TRUE.

Signature*: _____ DATE: _____

Printed Name: _____Relationship to Patient _____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

FACILITY RELEASING INFORMATION:

_____

_____

_____

_____

_____

FACILITY RECEIVING INFORMATION

HALLSVILLE MEDICAL CLINIC

209 W MAIN STREET STE D 873

HALLSVILLE, TX, 75650

903-668-7462 (P)

903-668-7400 or 903-630-8676 (F)

THE PURPOSE OF THIS RELEASE OF INFORMATION IS TO PROVIDE CONTINUITY OF MY CARE, FOR PROCESSING AN INSURANCE CLAIM, OR TO MEET ANOTHER SPECIFIC DESIRE OF MINE. THIS INFORMATION MAY INCLUDE TREATMENT FOR DRUG AND/OR ALCOHOL ABUSE, PSYCHIATRIC ILLNESS, HIV TEST RESULTS, OR AIDS DIAGNOSIS, AND/OR OTHER COMMUNICABLE DISEASES. THIS RELEASE IS TO INCLUDE

- ✓ OFFICE VISIT SUMMARY
- ✓ LABORATORY REPORT
- ✓ RADIOLOGY REPORTS
- ✓ IMMUNIZATION REPORTS
- ✓ HISTORY AND PHYSICAL EXAM
- ✓ CONSULTATION REPORT
- ✓ PATHOLOGY REPORTS
- ✓ ALL RECORDS ON FILE

TO ASSIST IN IDENTIFICATION AND LOCATION OF MY RECORDS I AM PROVIDING THE FOLLOWING INFORMATION:

NAME WHEN TREATMENT OCCURRED: _____

ADDRESS GIVEN AT THAT TIME: _____

_____

DATE OF BIRTH: _____

Signature*: _____ DATE: _____/_____/_____

Witness: _____

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NOTICE TO PERSON OR AGENCY RECEIVING INFORMATION:

FEDERAL AND STATE LAWS AND REGULATIONS PROHIBIT FURTHUR DISCLOSURE OF THE INFROMATION WHOSE CONFIDENTIALITY IS PROTECTED IN THE ABSENCE OF A SPECIFIC CONSENT OF THE PATIENT OR PERSON AUTHORIZED TO CONSENT FOR THE PATIENT.