

## Patient Consent and Release Forms

### **CONSENT FOR TREATMENT AND UNDERSTANDING OF FINANCIAL RESPONSIBILITY**

The patient agrees to general medical treatment by Lakeside Family Health Care and understands and consents to the review and use of his/her medical records by our office. All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. However, it is understood and agreed to, that the patient is responsible for all fees, including remainder of deductibles, regardless of insurance coverage. It is customary to pay for services when rendered, unless other arrangements have been made in advance.

### **INSURANCE AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS**

I hereby authorize Lakeside Family Health Care to furnish information concerning my medical condition and treatment thereof to my insurance carriers. I also assign insurance benefits to be paid on my behalf to Lakeside Family Health Care by any and all insurance companies that cover the expenses I incur as the result of any diagnostic services or treatment provided to me by Lakeside Family Health Care. I further agree that this authorization to release information and assignment of benefits shall remain in effect unless and until it is revoked by me, in writing.

**AUTOMATED CALLS:** I consent to receive automated phone calls regarding appointments, including patient portal communication.  YES  NO

**MEDICATION HISTORY:** I consent that my medication history may be downloaded from Sure Scripts to properly manage my care.  YES  NO

**VACCINE HISTORY:** I consent that my vaccines may be downloaded from IMMTRAC through the Texas Department of Health Services (DSHS).  YES  NO

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Signature	Date of Birth	Date
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## **NOTICE OF PRIVACY PRACTICES**

To our patients: This notice describes how health information about you (as a patient of this practice) may use and disclose, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Information Portability and Accountability Act of 1996 (HIPAA).

### **OUR COMMITMENT TO YOUR PRIVACY**

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with this important information. For a complete guide of the privacy practices of our office regarding your health information rights, please review the notebook in the waiting room. If you would like a copy to retain for yourself please request this from our front desk staff.

I acknowledge that I have been presented with the Notice of Privacy Practices as well as the Office Protocol and understand my responsibilities.

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<b>Signature</b>	<b>Date of Birth</b>
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<b>Signature of Patient or Legal Representative</b>	<b>Date</b>
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**AUTHORIZATION FOR MEDICAL RECORDS**

I hereby authorize: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

to disclose my individually identifiable health information as described below, which may include information concerning communicable disease such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

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<b>Print Patient Name</b>	<b>Date of Birth</b>	<b>Social Security Number</b>
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**Description of information to be released:**

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Purpose of the use and/or disclosure: **CONTINUATION/CO-ORDINATION OF CARE**

The health information described herein shall be released to:

**Lakeside Family Health Care  
6701 Heritage Pkwy, Suite 165  
Rockwall, TX 75087**

**Phone 972-460-3500      Fax: 972-460-3501**

I further understand that I may revoke this authorization at any time by notifying you in writing. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

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Signature of Patient

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Date

## Patient Registration Form

Name: \_\_\_\_\_  
(Last) (First) (Middle)

Name you prefer to be called: \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Social Security Number \_\_\_\_\_ Sex: M or F

Marital Status \_\_\_\_\_ Dominant Hand \_\_\_\_\_ Language Preferred \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Phone: Work \_\_\_\_\_ Home \_\_\_\_\_ Cell \_\_\_\_\_

Mailing Address \_\_\_\_\_

City, State, Zip (+4) \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Emergency Contact/Relationship to Patient \_\_\_\_\_

Whom shall we thank for referring you to our office? \_\_\_\_\_

### **INSURED PARTY INFORMATION (if different from patient information)**

Insured Party Name: \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Social Security Number \_\_\_\_\_ Sex: M or F

### **PREFERRED PHARMACY:**

Pharmacy Name: \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

## **DISCLOSURE AUTHORIZATION**

As stipulated by the HIPAA privacy rule, patients have the right to control how and to whom their protected medical information is given. Please instruct below how you would like the staff at Lakeside Family Health Care to contact you.

**I wish to be contacted in the following manner:**

- OK to leave message with detailed information at home
- OK to leave message with call back number only at home
  
- OK to leave message with detailed information at work
- OK to leave message with call back number only at work
  
- OK to mail to my home address

### **WHOM TO CONTACT**

In order to further protect your privacy, we will only disclose and/or discuss your healthcare information to members of your family, or others close to you, if you authorize us to do so.

Therefore, if you permit Lakeside Family Health Care to disclose information related to your medical condition(s) please list their information below:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

- I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that request for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

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Printed Patient Name

Date of Birth

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Signature of Patient or Legal Representative

Date

**Lakeside Family Health Care**  
**6701 Heritage Pkwy, Suite 165, Rockwall, TX 75087**  
**Phone 972-460-3500 Fax 972-460-3501**

## Lakeside Family Health Care

## Medical Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_

### **Past Medical History:**

Check (✓) conditions you have or have had in the past.

<input type="checkbox"/> AIDS	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Stroke
<input type="checkbox"/> Anemia	<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Herpes	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Veneral Disease
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Polio	
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Stone	<input type="checkbox"/> Prostate Problem	
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Measles	<input type="checkbox"/> Scarlet Fever	

**Past Surgical History:**

### **Hospitalization Other Than Surgery:**

## Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose	Drug Name	Dose

**Allergies to Medications, X-Ray Dyes, or Other Substances**  **No**  **Yes**  
(If yes, please list name of medicine and type of reaction)

**Family History:** Has any member of your family (including parents, grandparents and siblings) ever had the following?

Illness	Which family member?	Age when diagnosed
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart Disease		
Diabetes		
Strokes		
Mental disease (anxiety, depression, etc.)		
Drug or alcohol addiction		
Glaucoma		
Bleeding diseases		
Other		

## Immunization history — Have you had?

Hepatitis B Vaccine       No     Yes    When? \_\_\_\_\_      Pneumovax immunization?     No     Yes    When? \_\_\_\_\_  
Hepatitis A Vaccine       No     Yes    When? \_\_\_\_\_      Tetanus immunization?     No     Yes    When? \_\_\_\_\_

**Review of Systems:** Check (✓) symptoms you currently have or have had in the past year.

<b>General</b>	<b>Gastrointestinal</b>	<b>WOMEN only</b>
<input type="checkbox"/> Chills <input type="checkbox"/> Depression/Nervousness <input type="checkbox"/> Dizziness/Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	<input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Double vision <input type="checkbox"/> Earache/Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision - Flashes/Halos
<b>Muscle/Joint/Bone</b>	<b>Cardiovascular</b>	<b>Skin</b>
Pain, weakness, numbness in:	<input type="checkbox"/> Chest pain <input type="checkbox"/> High/Low blood pressure <input type="checkbox"/> Irregular/Rapid heart beat <input type="checkbox"/> Poor circulation <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	<input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching/Rash <input type="checkbox"/> Change in moles <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal
<b>Genito-Urinary</b>	<b>Eye, Ear, Nose, Throat</b>	<b>MEN only</b>
<input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination	<input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis
Date of last menstrual period _____		
Date of last Pap Smear _____		
Date of last mammogram _____		
Date of last bone density _____		
Date of last colonoscopy _____		
Pregnancies _____		
Birth _____ Miscarriage _____		

**Prevention**

Do you wear seat belts?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, why not? _____
Do you wear a bike helmet?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Do you exercise regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, type, duration and number of times per week? _____
Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many packs per day? _____
Do you drink alcoholic beverages?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much per week? _____
Do you drink coffee?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many cups per day? _____
Do you drink tea?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many cups per day? _____
If there is a gun in your home, do you keep it unloaded and out of children's reach?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Do you use drugs? (marijuana, cocaine, crack, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: _____
Have you ever engaged in any activity which has put you at risk of getting AIDS?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: _____
Do you wish to be tested for AIDS?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever worked with chemicals, paints, asbestos, or other hazardous materials?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: _____
Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you ever feel afraid of your partner?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Do you have a "living will"?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a donor card?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Signatures**

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient