BEST CHOICE PRIMARY CARE

PATIENT INFORMATION

Patient Name:_____DOB:_____Gender:___
Driver's License:_____SSN:_____
Home Phone:_____Cell:_____
Address: _____Zip Code_____
Email:_____
Employer: _____Position:_____
Employer Address:_____Phone:_____
Preferred Pharmacy:_____Phone:_____

EMERGENCY CONTACT INFORMATION

1.Name:_____Relationship:_____
Phone:_____Alternate Phone:_____
2.Name:_____Relationship:_____
Phone:_____Alternate Phone:_____
Is the patient a dependent? ___Guardian Name:_____
Guardian Phone:_____
Is the patient married?_____Spouse Name:_____
Spouse Phone:_____

INSURANCE

Insured Party:_____DOB:_____
Relation to Patient:_____
Company:_____Phone:_____
Address:_____
Policy No:_____Group No:_____
Dual Coverage?____2nd Insurance:_____
Policy No:_____Group No:_____
Payment Method:_____

I verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ X-Rays, photographs, anesthetics, medicines, surgeries, and other equipment or aids as he/she deems necessary in order to provide the proper patient care. I understand that payment, proof of insurance, and copay are due at the time of service. I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provided is factual and correct.

_____ _____

Signature **Date**

BEST CHOICE PRIMARY CARE

PATIENT MEDICAL INFORMATION

NAME:_____GENDER:__DOB:_____DATE:_____

ALLERGIES:_____

List ALL medications you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you do not know, please call your pharmacist to confirm.

_____ _____ _____

_____ _____ _____

_____ _____ _____

PERSONAL MEDICAL HISTORY (Please circle all that apply.)

ADHD
Alcoholism
Allergies, Seasonal
Anemia
Anxiety
Arrhythmia
(irregular heartbeat)
Arthritis
Asthma
Bipolar
Bladder Problems/
Incontinence
Bleeding Problems
Cancer:_____
Headaches
Crohn's Disease
COPD/Emphysema
Dementia
Depression
Diabetes: 1 or 2
Diverticulitis
DVT (Blood Clot)
GERD (Acid Reflux)
Glaucoma
Heart Disease
Heart Attack (MI)
Hiatal Hernia
High Blood Pressure
Kidney Stones
Kidney Disease
High Cholesterol
HIV
Hepatitis
Irritable Bowel Syndrome
Lupus
Liver Disease
Muscular Degeneration
Neuropathy
Osteopenia/Osteoporosis
Parkinson's Disease
Peripheral Vascular Disease
Peptic Ulcer
Psoriasis
Pulmonary Embolism (PE)
Rheumatoid Arthritis
Seizure Disorder
Sleep Apnea
Stroke
Thyroid Disorder
Ulcerative Colitis
Colonoscopy Date:_____
Normal/Abnormal

Females:
Last Menstrual Period
Date:_____
Normal/Abnormal
Mammogram
Date:_____
Normal/Abnormal
Dexa
Date:_____
Normal/Abnormal
Pap
Date:_____
Normal/Abnormal

Other medical problems not listed above:

_____

SURGICAL HISTORY

_____ _____

_____ _____

BEST CHOICE PRIMARY CARE

Patient Name _____

SOCIAL/CULTURAL HISTORY:

Education Level: Elementary High School Vocational College Graduate

Current Living Situation: Single Family Household Multi-generational Household

Homeless Skilled Nursing Facility

Are there any vision problems that affect your communication? Yes No

Are there any hearing problems that affect your communication? Yes No

Are there any limitations to understanding or following instructions, either written or verbal problems that affect your communication? Yes No

Smoking/Tobacco: Current Past Never Type_____Amt/Day_____Years_____

Alcohol: Current Past Never Drinks/Week_____

Recreational Drugs: Current Past Never Type_____

Are you sexually active? Yes No

Are there any personal problems or concerns at home, work, or school you would like to discuss? Yes No

_____

Are there any cultural or religious concerns you have related to our delivery of care? Yes No

Are there any financial issues that directly impact your ability to manage your health? Yes No

How often do you get the social and emotional support you need?

Always Usually Sometimes Rarely Never

Comments/Other concerns: _____

FAMILY HISTORY:

FATHER Living Age_____ Deceased Age_____

Alcoholism	Bipolar	Depression	HighBloodPress	Stroke
Anemia	Cancer _____	DVI(BloodClot)	Kidney Disease	ThyroidDisord
Asthma	COPD/Emphysema	Heart Disease	Migraines	
Arthritis	Dementia	HiCholesterol	Osteoporosis	

MOTHER Living Age_____ Deceased Age_____

Alcoholism	Bipolar	Depression	HighBloodPress	Stroke
Anemia	Cancer_____	DVI(BloodClot)	Kidney Disease	ThyroidDisord
Asthma	COPD/Emphysema	Heart Disease	Migraines	
Arthritis	Dementia	HiCholesterol	Osteoporosis	

SIBLINGS_____

Other Medical Providers you see on a regular basis: _____

_____

Patient Signature_____Date_____

BEST CHOICE PRIMARY CARE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT: _____Facility: *BEST CHOICE PRIMARY CARE*

Phone: _____Email: _____

Would you like our correspondence with you to be marked "Confidential"? Yes ☐ No ☐

May we identify ourselves over the phone? Yes ☐ No ☐

I have been given a copy of Best Choice Primary Care's *Notice of Privacy Practices ("Notice"*), which describes how my health information is used and shared. I understand that Best Choice Primary Care has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Facility Privacy Official, or by visiting the website at www.bestchoiceprimarycare.com .

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____

Signature of Resident or Personal Representative Date

_____

Print Name

_____

Personal Representative's Title

HIPAA DISCLOSURE

I, _____, hereby authorize Best Choice Primary Care to release my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following family members:

Name: _____DOB:_____ Relationship:_____

Name: _____DOB:_____ Relationship:_____

I further release my medical information to the following physicians, clinics, and/or hospitals:

Doctor: _____Clinic:_____ Phone:_____

Doctor: _____Clinic:_____ Phone:_____

Signature_____Date:_____

BEST CHOICE PRIMARY CARE

How Did You Hear About Us?

- **Insurance Directory Facebook Instagram**
- **RealSelf**
- **Patient Pop**
- **Newsletter/Magazine Ad**
- **Referred by Friend:_____**
  Other:_____

Like us on Facebook & follow us on Instagram
@bestchoiceprimarycare
Leave us a review!

For Facility Use Only: Complete this section if you are unable to obtain a signature on forms for any reason.

If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, for any reason please explain:

Describe the steps taken to obtain the patient (or personal representative's) signature on the *Acknowledgement:*

Completed by:

_____
Printed Name & Signature of Facility Representative

Date_____

BEST CHOICE PRIMARY CARE

Patient Registration Form
Disclosures & Consents

Patient Full Name: _____ Date of Birth: _____

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Best Choice Primary Care, PLLC or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are covered benefits. I understand and agree that I will be responsible for any co-pay or balance due that Best Choice Primary Care, PLLC is unable to collect from my insurance carrier whatever reason. J

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Best Choice Primary Care, PLLC or the physicians on my behalf.

AUTHORIZATION TO MAIL, CALL, OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to, such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Best Choice Primary Care, PLLC to that effect in writing.

LAB/X-RAY/DIAGNOSTIC/SERVICES:

I understand that I may receive a separate bill if my medical are includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my physician or his or her designee.

PATIENT SIGNATURE: _____ DATE: _____

GUARANTOR
SIGNATURE: _____ DATE: _____

GUARANTOR'S
PRINTED NAME: _____

BEST CHOICE PRIMARY CARE

MEDICAL RELEASE of RECORDS Form:

I, _____(Print Name), request that the following clinic:

Doctor/Clinic Name: _____

Phone: _____

Fax: _____

Release the following record for _____

DOB: _____

[ ] immunization record

[ ] labs/xrays within the past year

[ ] last wellness exam

[ ] all clinical notes

Signed: _____Date: _____

PLEASE FAX TO:

Jan Elliott MSN, APRN, FNP-C

Best Choice Primary Care
5525 Blanco Rd, SAT 78216
(210) 474-6020. FAX: 855-772-9540