Patient Registration Form

AGAPE Physicians

Patient History Form

Patient Name: ________________________________ **Date:** ____________________

Medications

Please list all medications you are currently taking, prescription and nonprescription, and their dosage:

Medications	Dose
______________	__________
______________	__________
______________	__________
______________	__________
______________	__________
______________	__________
______________	__________
______________	__________
______________	__________
______________	__________
______________	__________
______________	__________

ALLERGIES:

ARE YOU ALLERGIC TO ANY MEDICATIONS?

____ YES ____ NO

If yes, please list the name of the Medications and the type of reaction:

____

____

____

____

ARE YOU ALLERGIC TO ANY FOODS?

___ YES ___NO

If yes, please list: ________________________

____

Past Medical History

Please indicate if you have ever experienced any of the following conditions.

- ☐ Alcohol dependence
- ☐ Allergies (pollen, food)
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood clots
- ☐ Broken bones
- ☐ Cancer
  Type: ____________________
- ☐ Congestive heart failure
- ☐ COPD/Emphysema
- ☐ Depression
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Esophageal reflux
- ☐ Gallbladder stones
- ☐ Gout
- ☐ Heart Attack
- ☐ High blood pressure
- ☐ High Cholesterol
- ☐ Hypothyroidism
- ☐ Insomnia
- ☐ Irritable bowel syndrome
- ☐ Hepatitis
- ☐ Kidney Stones
- ☐ Fatty Liver Disease
- ☐ Migraines
- ☐Osteoporosis
- ☐ Seizures/epilepsy
- ☐ Sleep apnea
- ☐ Stomach ulcer
- ☐ Stroke (CVA)
- ☐ Other Chronic Diseases:

____

____

____

Surgical History

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Please check all that apply and the date of the procedure:

	Date		Date
☐ Angioplasty	____/____/____	☐ Gastric Bypass	____/____/____
☐ Angioplasty w/stent	____/____/____	☐ Hernia repair	____/____/____
☐ Appendectomy	____/____/____	☐ Hip replacement	____/____/____
☐ Back surgery	____/____/____	☐ Knee replacement	____/____/____
☐ Carpal Tunnel Release	____/____/____	☐ Liver Biopsy	____/____/____
☐ Cataract extraction	____/____/____	☐ Pacemaker	____/____/____
☐ Colon surgery	____/____/____	☐ Thyroidectomy	____/____/____
☐ Coronary Artery Bypass Graft	____/____/____	☐ Tonsillectomy	____/____/____
☐ Gallbladder (Cholecystectomy)	____/____/____	☐ Other: ____________________	____/____/____

Female Surgical History

Please check all that apply:

	Date
☐ Augmentation Mammoplasty	____/____/____
☐ Bilateral tubal ligation	____/____/____
☐ Breast biopsy	____/____/____
☐ Cesarean section	____/____/____
☐ D and C (dilation and curettage)	____/____/____
☐ Mastectomy	____/____/____
☐ Reduction Mammoplasty	____/____/____
☐ TAH/BSO Total Abdominal Hysterectomy)	____/____/____
☐ Vaginal Hysterectomy	____/____/____
☐ Other: ____________________	____/____/____

Male Surgical History

Please check all that apply:

	Date
☐ Prostate biopsy	____/____/____
☐ TURP (Trans-Urethral Resection of the Prostate)	____/____/____
☐ Vasectomy	____/____/____
☐ Other: ____________________	____/____/____

Family History

Please check if any family member has had any of the following conditions and indicate the name of the affected member, the age of onset and/or if it was the cause of death. **☐ Adopted**

	Mother	Father	Sibling(s)	Children
☐ Alcoholism				
☐ Alzheimer's				
☐ Heart disease				
☐ Cancer: Type: ________				
☐ Depression				
☐ Diabetes				
☐ High Cholesterol				
☐ Hypertension				
☐ Kidney Disease				
☐ Osteoporosis				
☐ Stroke				
☐ Seizures				

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Social History

Do you currently use tobacco? ☐ Yes ☐ No If yes, how many packs per day? ______________
What year did you start smoking?______
Have you previously smoked? ☐ Yes ☐ No If yes, how many packs per day? ______________
What year did you start smoking?______ What year did you stop smoking?___________
Other Tobacco units per day (cans, cigars, etc.)? ☐ Yes ☐ No

Units per day? __________ Years used? __________ Year quit? __________

Do you drink caffeine? ☐ Yes ☐ No Type?__________________________ Amount Daily? _______
Do you drink alcohol? ☐ Yes ☐ No ☐ daily ☐ weekly ☐ monthly Amount: __________________
What do you typically drink?____

Immunizations

Do you have copies of your immunization records? ☐ Yes ☐ No

Preffered Pharmacy Information

1. **Local Pharmacy:_______________________________________ Phone Number: ____________________**

   Address:____

2. **Mail In Pharmacy:_____________________________________ Phone Number: ____________________**

   Address:____

HEALTH MAINTENANCE (if applicable)

Last Mammogram: __________________________ Results: _________________________________

Last Well Woman/Well Male Exam: ___________________________

Colonoscopy: ______________________________ Results: _________________________________

Last PAP Smear : __________________________________ Results: _________________________________

Flu Vaccine Date: __________________________________

Pneumonia Vaccine Date: ___________________________

Tetanus Vaccine Date:______________________________

ADDITIONAL INFORMATION

____

____

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AGAPE Physicians

PATIENT INFORMATION IN THIS SECTION ONLY

Last Name: ___________________________________ First Name: _________________________________

Social Security Number: ______-______-______ Sex: ______ Female ______Male

Marital Status: **Married Single Divorced Widowed** (please circle)
Date of Birth ____/____/____
Address:
____
City: ______________________________ State: __________________ Zip:
____

Cell Phone: (____)______________ Day Phone:(____)_______________ ___Work Phone:( )_________
Email address:
____
Emergency Contact:
____
Phone Number: (____)________________ Relationship: ____

RESONSIBLE PARTY: THIS SECTION IS FOR ADULT WHO HOLDS THE INSURANCE
Relationship to Patient: **SELF PARENT SPOUSE** (please circle)(if self, do not continue this section)
Last name: ______________________________________ First Name: ______________________________
Social Security Number: ______-______-______ Sex: ______ Female ______ Male
Date of Birth: ______/______/______
Address:
____
City: ___________________________________ State: ______________________ Zip:
____

Cell Phone: (____) ______________ Day Phone: (_____) _______________ Work: (______) __________

INSURANCE AUTHORIZATION/ASSIGNMMENT & CONSENT FOR TREATMENT

I hereby authorize CHI St. Luke's/BSLMG to furnish information to all legitimately involved parties concerning my illness and treatment and that I hereby assign to CHI St. Luke's/BSLMG all payments for medical services rendered to myself or to my dependents. I understand that I am responsible for all changes. I consent to and authorize CHI St. Luke's/BSLMG to treat any condition that might have and seek treatment for.
I also understand and agree that I am ultimately financially responsible for services provided to myself and dependents. These services are to included: charges that are wither denied or not covered by my insurance policy, co-pays, and co-insurances as designated by my insurance policy; a deposit of $200 will be required for those services provided without insurance coverage. I further understand that I may receive additional billing form outside vendors; e.g. Radiology, Pathology, Laboratory, Durable Medical Equipment, etc.

Patient Signature: ____Date: _______________________

Parent/Legal Guardian Signature ________________________________Date: _______________________

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CONSENT FOR TREATMENT

I voluntarily give my permission to the health care providers of GHPMA and such assistants as they may deem necessary to provide medical care services to me. I understand that by signing this form, I am authorizing them to treat me as long as I seek care from GHPMA providers, or until I withdraw my consent.

____

Signature of Patient or Guardian Date

____

Printed Name of Patient or Guardian Relationship to Patient

____

Witness Signature Date

A duplicate or faxed copy of this form is considered the same as the original document.

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PATIENT AUTHORIZATION
TO RELEASE
PROTECTED HEALTH INFORMATION
TO DESIGNATED REPRESENTATIVE(S)

I, ___________________________(patient's name), give my authorization to release my protected health information including results of my laboratory tests, x-ray and/or other test results to the following designated representative(s):

Patient Initials

___________ My spouse (Name) ____________________________________

___________ My child (Name) ____________________________________

___________ Other (Name) ____________________________________

___________ Personal Representative ____________________________________

___________ May be left on my answering machine at home.

___________ May be left on my answering machine at work.

___________ May be left on my cell phone. _________________________________

___________ MAY NOT BE GIVEN TO ANYONE OTHER THAN MYSELF.

____ _________________________
Patient Signature Date

____ _________________________
Witness Date

As a patient, you have the right to revoke this authorization in writing at anytime, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, CHI St. Luke's/BSLMG must receive the revocation in writing. The revocation must include, 1) the patient's name, address, and date of birth, 2) the patient's desire to revoke the authorization, and 3) the date of the revocation and the patient's signature. All revocations must be sent in writing to the attention of Dina Hafley 6769 Lake Woodland Dr. Ste. E, The Woodlands, TX, 77382 or faxed to (281) 210-1210 and will not be considered effective until received by Dina Hafley and documented in patients chart.