



REGISTRATION FORM
(Please Print)

Today's date:				PCP:			
PATIENT INFORMATION							
Patient's Last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			City:	State:		Zip:	
Social Security #:		Email address:		Home Phone:		Cell Phone:	
Occupation:		Employer:			Employer phone no.: ()		
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Internet	<input type="checkbox"/> Other			
If other, please tell us where:							
INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date: / /	Address (if different):			Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:	Employer:	Employer address:			Employer phone no.: ()		
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> Medicare	<input type="checkbox"/> BCBS PPO	<input type="checkbox"/> United Healthcare	<input type="checkbox"/> Cigna	<input type="checkbox"/> Tricare	
<input type="checkbox"/> Aetna	<input type="checkbox"/> Humana	<input type="checkbox"/> AARP	<input type="checkbox"/> Other		<input type="checkbox"/> Other		
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):		Subscriber's name:			Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY		
Name of local friend or relative to contact:	Relationship to patient:	Phone Number:
_____	_____	_____
<p>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 Celina Health and Wellness or insurance company to release any information required to process my claims.</p>		
<p>_____</p> <p>Patient/Guardian's Signature</p>		<p>_____</p> <p>Date</p>



INFORMATION NEEDED

Celina Health and Wellness would like this information to help them in your medical needs.

1. Languages Spoken:

2. Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino
- Unknown
- Decline to answer

3. Race (can mark more than one; if multiracial):

- Alaskan Native
- American Indian
- Asian
- African American / Black
- Caucasian / White
- Indian
- Native Hawaiian or other Pacific Islander
- Unknown
- Decline to answer

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician and/or other individuals he/she deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical conditions. This consent is valid for each visit I make to Celina Health and Wellness unless revoked by me in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidentally exposed to a patient's blood or bodily fluids, such as through a needle stick (any such test shall be conducted pursuant to Celina Health and Wellness infectious disease protocol); or 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or bodily fluids. This disclosure is to inform you that you may be tested, at the expense of Celina Health and Wellness if any of those situations occur during your treatment period.

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Patient's Printed Name

Date of Birth

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Patient/Legal Representative's Signature

Today's Date

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Relationship to Patient

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Witness

Today's Date



FINANCIAL POLICY

Thank you for choosing Celina Health and Wellness as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy.

Patient Name: _____ Date of Birth: _____

All patients must read and sign this form prior to receiving services. Please initial before each section

___ **It is your responsibility to provide us with your most current insurance information at time of each visit.**

___ All services are provided to you with the understanding that you are responsible for the cost regardless of your insurance coverage. If you would like to know the estimated cost of the services, please inquire prior to treatment. Please be aware that not all services are a covered benefit with different insurance companies. We have no way of knowing every insurance companies plans and benefits so YOU are responsible for knowing what services are or are not covered. KNOW YOUR BENEFITS.

___ We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, **your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your** insurance company.

___ We will bill your insurance company as a courtesy, but you are still ultimately responsible for payment of all services you receive. If your insurance company does not respond to our claim, a statement will be sent to you. You will have to call the insurance company to work out your statement; our office will assist you only after you have contacted your insurance.

___ Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we received from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim-regardless of our estimation.

___ **It is your responsibility to provide us with your most current billing information.** You must provide your most current billing address at each visit, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.

___ **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 90 days of the statement issue date are deemed past due.

___ If your account is past due for an amount more than \$200 (two hundred dollars), you will not receive services from any physicians at Celina Health and Wellness and will be dismissed from the practice. Failure to accept the certified letter (and/or to pick it up at the post office) serves as notice of termination of services.

___ In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add \$35.00 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.

___ You will be charged a "No Show" fee of \$30 if you fail to cancel or reschedule your appointment at least 24 hours prior your appointment date. Cancelling the appointment the same day is not 24 hour notice; and a "no show" fee will still be charged unless emergency reason.

___ **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

___ Full payment is due at time of service. We accept cash, checks, and credit cards.

___ We do understand that temporary financial problems may affect timely payments. We encourage you to communicate any such problems and ask about our "Agreement to Pay for Physician Services" Plan.

By signing this; you are agreeing to the clear understanding of our financial policy and how it is important to the relationship with Celina Health and Wellness. Please ask if you have any questions.

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Signature of Responsible Party

Date



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand Celina Health and Wellness reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy on the clinic website and in the physician’s office. I may request a copy of the updated Notice of Privacy Practices by calling my physician’s office or requesting a copy in person at any of my appointments.

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Patient’s Printed Name Date of Birth

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Patient/Legal Representative’s Signature Date

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Relationship to Patient

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Witness Date

I wish to be contacted in the following manner: **(Please list phone number that is best number for nurses to call)**

Telephone Number: _____

- Ok to leave message with detailed information.
- Leave message with call-back number only.

Email address: _____

- I authorize Celina Health and Wellness to contact me using the email address provided above.
- I understand my name, information regarding my account balance could be viewed by anyone who has access to my email and that if my email is unsecured, the information could potentially be intercepted.

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Celina Health and Wellness to share my protected health information with:

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Name/Relationship Contact Phone Number

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Name/Relationship Contact Phone Number

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Name/Relationship Contact Phone Number

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Name/Relationship Contact Phone Number

PATIENT PORTAL

- Patient does want to receive access to health information.
- Patient does **not** want to receive access to health information.



Welcome to our practice. Please fill out the information below to the best of your ability.

Physician: _____ Date: _____

Patient Name: _____ Reason for Visit: _____

Personal Medical History			Previous Surgeries/Serious Injuries (When?)
Diabetes (Type _____)	N	Y: Date _____	_____
High Blood Pressure	N	Y: Date _____	_____
Cancer (Type _____)	N	Y: Date _____	_____
Stroke	N	Y: Date _____	_____
COPD	N	Y: Date _____	_____
High Cholesterol	N	Y: Date _____	_____
GERD	N	Y: Date _____	_____
Arthritis	N	Y: Date _____	_____
Gout	N	Y: Date _____	_____
Sleep Apnea	N	Y: Date _____	_____
Asthma	N	Y: Date _____	_____
Thyroid Disorder	N	Y: Date _____	_____
Allergic Rhinitis	N	Y: Date _____	_____
Other	N	Y: Date _____	_____
			Local Pharmacy _____

			Mail Pharmacy _____

Patient Social History

Use of Alcohol: Daily Weekly Monthly Occasionally Rarely Never

Use of Tobacco: Daily Previously, but Quit (Age Stopped _____) Never

Use of Drugs: Never Type/Frequency _____

Marital Status: Single Married Divorced Separated Widowed

Occupation: _____

Family Medical History

	Age	Diseases	If Deceased, Cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Brother(s)	_____	_____	_____
Sister(s)	_____	_____	_____
Son	_____	_____	_____
Daughter	_____	_____	_____



Patient Name: _____ Date of Birth: _____

Do you **currently** have any problems related to the following systems?

REVIEW OF SYSTEMS	
<p><u>CONSTITUTIONAL:</u></p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Chills</p> <p><input type="checkbox"/> <input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> <input type="checkbox"/> Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Weight Gain</p> <p><input type="checkbox"/> <input type="checkbox"/> Weight Loss</p>	<p><u>GENITOURINARY:</u></p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Dysuria (painful urination)</p> <p><input type="checkbox"/> <input type="checkbox"/> Hematuria (blood in urine)</p> <p><input type="checkbox"/> <input type="checkbox"/> Urinary frequency</p>
<p><u>HEENT:</u></p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Ear pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Eye pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Sinus pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Sore throat</p>	<p><u>INTEGUMENTARY (SKIN):</u></p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Hair loss</p> <p><input type="checkbox"/> <input type="checkbox"/> Rash</p>
<p><u>RESPIRATORY:</u></p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Cough</p> <p><input type="checkbox"/> <input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> <input type="checkbox"/> Wheezing</p>	<p><u>NEUROLOGICAL:</u></p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> <input type="checkbox"/> Extremity numbness</p> <p><input type="checkbox"/> <input type="checkbox"/> Headache</p>
<p><u>CARDIOVASCULAR:</u></p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Chest Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Edema</p>	<p><u>PSYCHIATRIC:</u></p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> <input type="checkbox"/> Depression</p> <p><input type="checkbox"/> <input type="checkbox"/> Insomnia</p>
<p><u>GASTROINTESTINAL:</u></p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Abdominal Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood in stools</p> <p><input type="checkbox"/> <input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> <input type="checkbox"/> Diarrhea</p>	<p><u>Musculoskeletal:</u></p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Back pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Joint pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Neck pain</p>



Health Maintenance Flow Record

Patient Name: _____

Date of Birth: _____

Test	Date Performed	Normal or Abnormal?
Bone Density		
Colonoscopy		
Eye Exam		
Foot Exam		
Echocardiogram		
Endoscopy		
EKG		
Spirometry		
Stress Test		

Male Patients Only

PSA Blood Test		
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Female Patients Only

Mammogram		
Pap Smear		

Immunizations

Hep A vaccine	
Hep B vaccine	
Twinrix	
HPV vaccine	
Menactra vaccine	
MMR vaccine	
Pneumonia vaccine	
Tetanus vaccine	
Varicella vaccine	
Zostavax vaccine	