Celina Medical Clinic

Patient Information

Please print clearly and complete all information requested. Thank you!

Patient Last Name _____ First Name _____

Mailing Address _____ City_____ State ____ Zip_____

Home # _____ Cell # _____ Work # _____

DOB _____ Sex: M F **Marital Status:** M S D W **Social Security # _____**

In case of emergency, please contact _____ Phone _____

Do you have advanced directives? YES NO If yes, where are they kept? _____

Instructions for leaving messages or giving medical information:

May we speak to:

Your Spouse	____ Yes	____ No	____ Initials
Your Parent / Child	____ Yes	____ No	____ Initials
Speak only to me	____ Yes	____ No	____ Initials

May we leave a message on:

Answering Machine	____ Yes	____ No	____ Initials
Cell Phone	____ Yes	____ No	____ Initials
Work Voicemail	____ Yes	____ No	____ Initials

If there is anyone else you authorize us to give medical information to, please specify:

_____

Office Policies

As our patient, Celina Medical Clinic is legally required to have certain patient information on file. This includes but is not limited to a current Texas driver's license, our Patient Information form completely filled out and current insurance card if filing with insurance today.

Payment for all professional services is expected at the time services are rendered, unless alternative arrangements have been made in advance. All deductibles and co-payments must be paid at the time of the office visit. Celina Medical Clinic does not file with Medicaid or CHIPs. Celina Medical Clinic does not file worker's compensation claims or motor vehicles accidents.

Services provided for a minor are the responsibility of the accompanying adult, regardless of custodial status. I understand it is the policy of this office to report any delinquent balances to the credit bureau. I authorize the release of any medical information necessary to process insurance claims and authorize payment of medical benefits to the party, which accepts assignment for the services rendered.

Due to the increase in medical documentation for other agencies, Celina Medical Clinic will charge a $25.00 fee for filling out those forms. Payment is required prior to the form being filled out.

When requesting medication refills, please allow 24-48 hours for Celina Medical Clinic to respond.

I have completed this form fully, and I certify that I am the patient or the general agent or legal guardian of the patient duly authorized to furnish the information requested. I understand that I am fully responsible for payment of all services performed at the time they are rendered, with exceptions only as listed above.

If we are filing with insurance please understand that by signing below, you agree you are financially responsible for whatever insurance does not cover. I have received the Notice of Privacy Practices and the Celina Medical Clinic Financial Policy and I have been provided an opportunity to review it.

Patient or Guardian Signature _____ Patient or Guardian Printed Name _____

Date _____

Health Questionnaire

Current Medications

(List all medications you are currently taking. Include over the counter medication as well.)

Name / Strength / How Often _____
Name / Strength / How Often _____
Name / Strength / How Often _____

Name / Strength / How Often _____
Name / Strength / How Often _____
Name / Strength / How Often _____

Patient Medical History

Decreased hearing	**Y N**	Difficulty swallowing	**Y N**	Numbness/Tingling sensations	**Y N**
Ringing in ear	**Y N**	Indigestion or heart burn	**Y N**	Headaches - frequent	**Y N**
Ear infections – frequent	**Y N**	Abdominal pain/Chronic	**Y N**	Arthritis/Rheumatism	**Y N**
Dizzy spells	**Y N**	Diverticulosis	**Y N**	Back pain – frequent	**Y N**
Glaucoma	**Y N**	Blood in stools	**Y N**	Rashes	**Y N**
Failing vision	**Y N**	Hemorrhoids	**Y N**	Hives	**Y N**
Cataracts	**Y N**	Hernia	**Y N**	Memory loss	**Y N**
Nose bleeds	**Y N**	Hepatitis A, B or C	**Y N**	Recent hair loss	**Y N**
Sore throats – frequent	**Y N**	Urine infections – frequent	**Y N**	Herpes	**Y N**
Hoarseness - prolonged	**Y N**	Kidney stones	**Y N**	Chicken Pox	**Y N**
Pneumonia/Pleurisy	**Y N**	Venereal Disease	**Y N**	Other:	
Bronchitis/Chronic Cough	**Y N**	Chronic Fatigue	**Y N**	Other:	
Asthma/Wheezing	**Y N**	Weight Loss – recent	**Y N**	Other:	
Chest pain	**Y N**	Weight Gain – recent	**Y N**	***Females only:*** Hysterectomy _____ (year)	**Y N**
High blood pressure	**Y N**	Anemia	**Y N**	***Females only:*** Date of last mammogram _____	
Heart murmur	**Y N**	Cancer	**Y N**	***Females only:*** No. of pregnancies _____	
Fainting spells	**Y N**	Thyroid Disease	**Y N**	***Females only:*** No. of c-sections _____	
Sleeping difficulty	**Y N**	Convulsions/Seizures	**Y N**	***Females only:*** No. of miscarriages _____	
Varicose Veins	**Y N**	Loss of appetite	**Y N**	***Females only:*** Birth control method_____	
Diabetes	**Y N**	Tremor/Hands shaking	**Y N**	***Females only:*** Menstrual history/ Reg___ Irreg__	
Stroke	**Y N**	Depression	**Y N**	***Females only:*** Date of last pap _____	

*Drug Allergies*_____

Surgeries

Year / Surgery	
Year / Surgery	
Year / Surgery	

Hospitalizations

Year / Illness	
Year / Illness	
Year / Illness	

Medical conditions in your family:

Father	Alive Deceased
Mother	Alive Deceased
Sibling 1	Alive Deceased
Sibling 2	Alive Deceased
Sibling 3	Alive Deceased
Paternal Grandfather	Alive Deceased
Paternal Grandmother	Alive Deceased
Maternal Grandfather	Alive Deceased
Maternal Grandmother	Alive Deceased
Other	Alive Deceased

Social History:

Tobacco use:	No Yes
Alcohol:	No Socially Yes
Drug use:	No Yes
Children:	___ # sons ___ # daughters
Occupation	
Exercise:	No Yes
Caffeine:	No Yes
Sexually active:	No Yes