

# 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 \_\_\_\_\_

How did you hear about us? (if there is someone who referred you please list their name so we know who to thank)

\_\_\_\_\_

Do you have advanced directives (a living will)? YES NO If yes, where are they kept? \_\_\_\_\_

### Instructions for leaving messages or giving medical information:

May we speak to:

May we leave a message on:

Your Spouse	___ Yes	___ No	___ Initials	Answering Machine	___ Yes	___ No	___ Initials
Your Parent /Child	___ Yes	___ No	___ Initials	Cell Phone	___ Yes	___ No	___ Initials
Speak only to me	___ Yes	___ No	___ Initials	Work Voicemail	___ Yes	___ No	___ Initials

If you would like us to email you information please give us your email address: \_\_\_\_\_

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, the dose, how often you are taking and the reason you are taking the medication. Include over the counter medication as well.)

Name / Strength / Reason _____	Name / Strength / Reason _____
Name / Strength / Reason _____	Name / Strength / Reason _____
Name / Strength / Reason _____	Name / Strength / Reason _____

## 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	<i>Females only:</i> Hysterectomy (year)	Y N
High blood pressure	Y N	Anemia	Y N	<i>Females only:</i> Date of last mammogram	
Heart murmur	Y N	Cancer	Y N	<i>Females only:</i> No. of pregnancies	
Fainting spells	Y N	Thyroid Disease	Y N	<i>Females only:</i> No. of c-sections	
Sleeping difficulty	Y N	Convulsions/Seizures	Y N	<i>Females only:</i> No. of miscarriages	
Varicose Veins	Y N	Loss of appetite	Y N	<i>Females only:</i> Birth control method	
Diabetes	Y N	Tremor/Hands shaking	Y N	<i>Females only:</i> Menstrual history/ Reg Irreg	
Stroke	Y N	Depression	Y N	<i>Females only:</i> Date of last pap	

## Drug Allergies \_\_\_\_\_

Date of most recent labwork \_\_\_\_\_

### 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