THS MEDICAL CLINIC
Dr. Satiskumar Patel MD, MBChB

Please fill out entire form.

Today's Date: _____

Mr. Mrs. Miss Jr. Sr. Sex: M / F Marital Status: Single Married Other

Patient's Name: _____
Last First MI

Address: _____
City State Zip

Phone #: _____ _____ _____
Home Work Cell

Social Security #: _____ **DOB**: _____

Patient's Employer & Occupation: _____

Patient's Spouse: _____ Preferred Pharmacy: _____

Emergency Contact: _____ **Phone #**: _____

INSURANCE INFORMATION

Primary Insurance: _____

ID#: _____ Group#: _____

Subscriber: _____ _____ _____
Name DOB SS#

*****MUST have Subscriber's SS# in order to process all lab work and insurance claims.***

Secondary Insurance: _____

ID#: _____ Group#: _____

Subscriber: _____ _____ _____
Name DOB SS#

CASH/SELF PAY

List person responsible for bill if uninsured:

Name: _____
Last First MI

Address: _____
City State Zip

DOB: _____ SS#: _____ Phone#: _____

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PAYMENT POLICY

I hereby consent to a health examination, related diagnostic procedures and treatments provided by the THS Medical Clinic. I hereby authorize my insurance company(s) to remit directly to THS Medical Clinic all payment of benefits otherwise payable to me under the provision of my policy(s). I request that payment of authorized Medicare/Medicaid benefits be made either to me or on my behalf to THS Medical Clinic for any services provided to me. I hereby authorize the release of this information needed to determine benefits payable for related services.

*****If my insurance company requires referrals, vouchers or authorizations, I will present these to the receptionist immediately. Failure to do so will make me responsible for full payment once services are rendered.***

_____ _____
Signature Date

****

WORKMAN'S COMPENSATION

If Workman's Compensation, please give the name, address, and telephone number of your employer so we may process the claim.

Employer Contact: _____ **Phone#:** _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Phone#: _____

Address: _____ City: _____ State: _____ Zip: _____

Claim #: _____

_____ _____
Signature Date

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Patient Authorization for Use and Disclosure of Protected Health Information

Please list at least one person you will permit to view, pick up, and/or sign for your Medical Records in the event you can not do so yourself. If there is no one you wish to appoint, please sign your name.

_____ _____
Name Relationship

_____ _____
Name Relationship

I understand that I do not have to sign this authorization in order to receive treatment from THS Medical Clinic. I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

THS Medical Clinic
108A North Main Street
Dayton, TX 77535

I understand that this authorization permits THS Medical Clinic to use and/or disclose any and/or all individually identifiable health information about myself.

_____ _____
Signature Date

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Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I was provided with a copy of the Notice of Privacy Practices to read (or had the opportunity to read if I so choose) and understood the Notice.

I would like a copy of the Privacy Practices. YES _____ NO _____
(Please mark answer and initial)

_____ _____
Patient Name *(please print)* Date

_____
Parent or Authorized Representative *(if applicable)*

_____
Signature

I agree that Dr. Patel or his office staff may leave messages at my home either with a person or on a machine regarding medical information. YES _____ NO _____

If there is someone that you do NOT want information left with, please specify:

_____
Person/Persons

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PATIENT'S RIGHTS AND RESPONSIBILITIES

As a patient you have certain rights and responsibilities. We recognize that a respectful relationship between the healthcare provider and the patient is the foundation of proper medical care. Copies of this statement are posted in our patient care waiting areas.

Patients have the right to:

- Receive humane care and treatment, with respect and consideration.
- Privacy and confidentiality when seeking or receiving care except for life threatening conditions or situations.
- Confidentiality of your health records.
- Be informed of and to exercise the option to refuse to participate in any research aspect of your care without compromising access to medical care and treatment.
- Receive accurate information concerning diagnosis, treatment, risks involved, and prognosis of an illness or health related condition.
- Ask about reasonable alternatives to care.
- A second professional opinion regarding one's health care and treatment.
- Participate actively in decisions regarding one's health care and treatment.
- Accessible information regarding the scope and availability of services.
- Be informed about any legal reporting requirements regarding any aspect of screening or care.

Patients have the responsibility to:

- Provide complete information about one's illness/problem, to enable proper evaluation and treatment.
- Ask questions so that an understanding of the condition or problem is ensured.
- Show respect to health personnel and other patients.
- Reschedule/cancel an appointment so that another person may be given that time slot.
- Pay bills or file health claims in a timely manner.
- Use prescription or medical devices for oneself only.
- Inform the practitioner(s) if one's condition worsens or an expected reaction occurs from a medication.

_____ _____

Patient/Legal Guardian Signature Date

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GENERAL MEDICAL HISTORY

Patient Name: _____ DOB: _____ Age: _____ Sex: M F

Marital Status: Single Married Other Occupation: _____

1. Patient Medical History: (*check if applicable*)

_____ High Blood Pressure	_____ Diabetes	_____ Asthma	_____ Thyroidism
_____ Heart Problems	_____ ADD/ADHD	_____ Seizures	_____ Gout
_____ Acid Reflux	_____ COPD	_____ CHF	_____ Seasonal Allergies
_____ Depression	_____ Anxiety	_____ Chronic Pain	_____ Insomnia
_____ Sleep Apnea	_____ Bronchitis	_____ Pneumonia	_____ High Cholesterol

_____ Cancer (*specify*): _____
_____ Other (*specify*): _____

2. Surgeries/Procedures, with dates: _____
_____

3. Medicines you are allergic to: _____

4. Are you currently taking any medications? Y / N ***(If YES, use back of page to list medications)***

5. Family Medical History: *(List all medical problems, if any)*
Refer to list in Patient Medical History, if needed.

Mother: _____

Father: _____

Siblings: _____

FEMALES:
Date of LMP**:** _____ Mammogram**:** _____ Pap**:** _____
Are you pregnant? Y / N

MALES:
Date of last Prostate/Rectal exam: _____

6. Social History:
Tobacco use: Y / N Type: _____ Quantity: _____ # of years: _____
Alcohol use: Y / N Type: _____ Daily / Weekly / Occasionally
Drug use: Y / N Type: _____

7. Do you have an **Advanced Directive for Healthcare** (Living Will)? **Y / N**

Signature: _____ **Date:** _____

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Name of Medication	Strength (mg)	Frequency