

**Lone Star Medical Group**  
**PATIENT REGISTRATION FORM (eCW)**

**PATIENT INFORMATION**

(Please print)

Patient's Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ DOB: \_\_\_\_\_

Sex:  Female  Male  Transgender

Race:  American Indian/Alaska Native  Asian  Native Hawaiian/Pacific Islander

Black/African American  White  Hispanic  Other  Declined

Language:  English  Spanish  Indian: Hindi, etc.  Japanese  Chinese  Korean  French  German  Russian  Other

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Declined

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION (If not self)**

(Information used for patient balance statements)

Responsible party:  Another patient  Guarantor  Self Check here if address and telephone information is same as patient

Responsible party name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Date of birth: MM \_\_\_\_/DD \_\_\_\_/YYYY \_\_\_\_

Sex:  Female  Male

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Phone number: \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_ ZIP: \_\_\_\_\_

**INSURANCE INFORMATION:** Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

**EMERGENCY CONTACT INFORMATION**

Emergency contact name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_

Phone number: \_\_\_\_\_ Do you have a living will?  Yes  No

Emergency contact relationship to patient: \_\_\_\_\_  Guardian

Address \_\_\_\_\_

City, State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work home: \_\_\_\_\_ Ext. \_\_\_\_\_

**GENERAL CONSENT FOR CARE AND TREATMENT CONSENT**

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name of patient or personal representative: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Patient name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

### Patient Consent for Financial Communications

#### Financial Agreement

- I acknowledge, that as a courtesy, LONE STAR MEDICAL GROUP may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

**Third Party Collection.** I acknowledge LONE STAR MEDICAL GROUP may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

**Assignment of Benefits.** I hereby assign to LONE STAR MEDICAL GROUP any insurance or other third-party benefits available for health care services provided to me. I understand LONE STAR MEDICAL GROUP has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to LONE STAR MEDICAL GROUP, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

**Medicare Patient Certification and Assignment of Benefit.** I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to LONE STAR MEDICAL GROUP by the Medicare or Medicaid program.

**Consent to Telephone Calls for Financial Communications.** I agree that, in order for LONE STAR MEDICAL GROUP, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that LONE STAR MEDICAL GROUP or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or LONE STAR MEDICAL GROUP or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

**Patient/patient representative signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

Spouse  
Parent  
Legal Guardian

Guarantor  
Healthcare Power of Attorney  
Other (please specify) \_\_\_\_\_

**New Patient History (Adult) To be completed by the Patient or Guardian**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Describe your main problems:

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List any allergies or adverse reactions:

Drug/Allergen:	Reaction:	Onset Date:
_____	_____	_____
_____	_____	_____
_____	_____	_____

NKDA (no known allergies)

List all medications you are currently taking, the dosage and the reason:

Name:	Dosage:	Reason:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all other providers you currently see:

Name:	Specialty:
_____	_____
_____	_____
_____	_____

**Past medical history:**

- |   |   |
|---|---|
| <input type="checkbox"/> Other: _____                       | <input type="checkbox"/> Heart problems       |
| <input type="checkbox"/> ADD OR ADHD                        | <input type="checkbox"/> Heart valve disorder |
| <input type="checkbox"/> Allergies                          | <input type="checkbox"/> Heart Arrhythmia     |
| <input type="checkbox"/> Anemia                             | <input type="checkbox"/> Heart attack (MI)    |
| <input type="checkbox"/> Anxiety disorder                   | <input type="checkbox"/> Heart murmur         |
| <input type="checkbox"/> Aortic aneurysm                    | <input type="checkbox"/> Hemophilia           |
| <input type="checkbox"/> Arrhythmia                         | <input type="checkbox"/> Hepatitis            |
| <input type="checkbox"/> Arthritis                          | <input type="checkbox"/> Hernia               |
| <input type="checkbox"/> Asthma                             | <input type="checkbox"/> Hiatal Hernia        |
| <input type="checkbox"/> Atrial Fib                         | <input type="checkbox"/> Hypercholesterolemia |
| <input type="checkbox"/> Back pain                          | <input type="checkbox"/> Hyperlipidemia       |
| <input type="checkbox"/> Bedwetting                         | <input type="checkbox"/> Hypertension         |
| <input type="checkbox"/> Birth defects or inherited disease | <input type="checkbox"/> Hyperthyroidism      |
| <input type="checkbox"/> Bleeding disorder                  | <input type="checkbox"/> Hypothyroidism       |
| <input type="checkbox"/> Blood clots                        | <input type="checkbox"/> Joint pain           |
| <input type="checkbox"/> Breast cancer                      | <input type="checkbox"/> Kidney disease       |
| <input type="checkbox"/> CAD                                | <input type="checkbox"/> Kidney stones        |
| <input type="checkbox"/> COPD                               | <input type="checkbox"/> Leg or foot ulcers   |

**Past medical history cont'd:**

- CVA
- Cancer
- Chest pain
- Chicken Pox
- Claustrophobic
- Congenital Heart Disease
- Congestive Heart Failure
- Constipation
- Depression
- Developmental or behavioral disorders
- Diabetes
- Dialysis
- Diverticulitis
- Ear or hearing problems
- Eczema, hives, or other skin conditions
- Endometriosis
- Epilepsy
- Eye problems
- Fibromyalgia
- GERD
- Gastrointestinal disease
- Genitourinary Disease
- Gout
- HIV or AIDS
- Head Trauma
- Headaches or Migraines
- Heart disease
- Liver disease
- Migraines
- Muscle, joint or bone problems
- Obesity
- Organ transplant
- Osteoarthritis
- Osteopenia
- Osteoporosis
- Otitis media
- Pacemaker
- Previous fracture
- Psychiatric illness
- Pulmonary embolism
- Rheumatoid arthritis
- Seizures
- Serious illness or injuries
- Shortness of breath
- Skin problems
- Sleep apnea
- Sleep disorder
- Stroke / CVA
- Thyroid problem
- Tuberculosis
- Ulcers
- Urinary tract infection
- Urologic disorder
- Alcohol or drug abuse

**Family History:**

	Diseases	Onset age	Died of age, if app'l
Father:	_____	_____	_____
Mother:	_____	_____	_____
Siblings:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse:	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
Other:	_____	_____	_____
	_____	_____	_____

**Surgical History:**

Procedure:	Surgery Date:
_____	_____
_____	_____
_____	_____

**Patient Social History:**

Smoking Status (select one):      Never                              Current every day smoker  
   Former Smoker                      Current occasional smoker

Smoking-How Much:                      \_\_\_\_\_ pack per day

Tobacco-years of use:                      \_\_\_\_\_

Occupation:                                      \_\_\_\_\_

Education (select last completed):    Less than 8<sup>th</sup> grade                      High school graduate  
   9<sup>th</sup> grade                                      2 year college  
   10<sup>th</sup> grade                                    4 year college  
   11<sup>th</sup> grade                                    Post graduate

Marital status:                              Unknown                                      Separated  
   Married                                        Widowed  
   Single                                         Domestic partner  
   Divorced

Sexual orientation:                        Heterosexual                              Homosexual                              Bisexual

Exercise level:                              None    Occasional  
   Moderate                                        Heavy

Diet:    Regular                                        Specific  
   Vegetarian                                    Carbohydrate  
   Vegan                                         Cardiac diabetic  
   Gluten free

General stress level:                        Low    Medium                                        High

Alcohol intake:                              None    Occasional  
   Moderate                                        Heavy

Alcohol-years of use:                      \_\_\_\_\_

Caffeine intake:                              None    Occasional  
   Moderate                                        Heavy

Chewing tobacco:                        None                              1/day                              2-4/day                              5+/day

Illicit drugs:                                      \_\_\_\_\_

Sunscreen used routinely:                Yes                              No

Smoke alarm in home:                      Yes                              No

Advance directive:                        Yes                              No

Sporting Activities:                        \_\_\_\_\_

Sexually active:                              Yes                              No

Passive smoke exposure:                Yes                              No

Family history of heart disease	Yes	No
Family history of heart disease before late 50's?	Yes	No
Sexually Transmitted Disease	Yes	No
At risk for Hip B?	Yes	No
At risk for TB?	Yes	No

**For female patients ONLY:**

Last menstrual period:	_____	Unknown	Approximate	Definite
Frequency of cycle (days):	_____			
Menses monthly	Yes	No		
Age of menarche:	_____			
Prior hysterectomy?	Yes	No		
Current birth control method:	_____			
If post menopausal, age at menopause:	_____			
Date of last pap:	_____			
# of child births:	_____			
# of pregnancies:	_____			
Sexually active:	Yes	No		

**Past pregnancies:**

Date: _____	# of Fetuses: _____	GA wks: _____	Labor Length (hrs): _____	Sex: M / F
	Delivery Type: _____	Anesthesia: _____	Delivery Place: _____	
	Preterm Labor: Y / N			
Date: _____	# of Fetuses: _____	GA wks: _____	Labor Length (hrs): _____	Sex: M / F
	Delivery Type: _____	Anesthesia: _____	Delivery Place: _____	
	Preterm Labor: Y / N			
Date: _____	# of Fetuses: _____	GA wks: _____	Labor Length (hrs): _____	Sex: M / F
	Delivery Type: _____	Anesthesia: _____	Delivery Place: _____	
	Preterm Labor: Y / N			
Date: _____	# of Fetuses: _____	GA wks: _____	Labor Length (hrs): _____	Sex: M / F
	Delivery Type: _____	Anesthesia: _____	Delivery Place: _____	
	Preterm Labor: Y / N			

**MEDICATION PRESCRIPTION POLICY AND AGREEMENT**

The following is an outline of our medication prescription refill policy here at Lone Star Medical Group.

1. If you need a refill on your medication, we ask that you call **your pharmacy** and tell them which medication you need refilled. They, in turn, will fax or call us with all the information we need to refill the medication. **If you call us, we will ask you to call your pharmacy.**
  
2. **We do not refill medications after business hours or on weekends.** Our providers do not have access to your medical records after business hours. Please make sure you contact your pharmacy **at least 3 days before you run out of the medication** to allow time for the refill to be processed. Any calls for medication received after 3:30 PM will not be addressed until the following business day.

**AFTER BUSINESS HOURS , WEEKENDS AND HOLIDAYS**

Our normal business hours are 8 AM to 12 PM and 1:30 PM to 5 PM, Monday through Friday. We are closed on major holidays. This can vary by provider, so be sure to ask your provider the clinic hours. In case of an emergency, a life-threatening situation, or concerning symptoms, call 911 or go to the nearest emergency room.

Our providers do not have access to your medical records after business hours, weekends, or major holidays. If you would like to schedule a routine appointment, please call during business hours.

**LATEX ALLERGY NOTIFICATION (check one)**

- I am not allergic to latex.
  
- I am allergic to latex.

I have read and understood the above policies and agree to adhere to the policies.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Parent/Legal Guardian name: \_\_\_\_\_

Witness Signature: \_\_\_\_\_