232 Brite Rd. #117
Cibolo, TX. 78108

Affinity Family Care Clinic

Phone: (210) 247-2248
Fax: (210) 368-6270

PATIENT REGISTRATION FORM

NAME: LAST _____FIRST _____ MI _____ **DOB:** _____

ADDRESS_____ **CITY**_____**STATE**_____**ZIP**_____**EMAIL**_____

PHONE NUMBER: _____ **PREFERRED PHARMACY:** _____

Previous Primary Care _____

EMERGENCY CONTACT/RELATIONSHIP: _____**PHONE NUMBER:** _____

ALLERGIES: ☐NO KNOWN ALLERGIES ☐OTHER: _____

REASON FOR VISIT TODAY: _____ **DATE OF ONSET OF SYMPTOMS:** _____

CURRENT MEDICATIONS: PLEASE LIST **ALL** PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS (INCLDING VITAMINS AND SUPPLEMENTS): (MEDICATION/DOSE/HOW OFTEN) _____
_____
_____

(FEMALES) ARE YOU PREGNANT?☐YES☐NO DATE OF LAST MENSTRUAL CYCLE? _____

LIST ALL CURRENT AND PAST MEDICAL HISTORY: ☐Headaches ☐High Blood Pressure ☐Arthritis ☐Bone/Joint Disease ☐Prostate Disease ☐Gastritis/Ulcer ☐Depression/Anxiety ☐Diabetes ☐HIV ☐Asthma/COPD ☐Chest Pain/Heart Disease ☐Hepatitis ☐Gout ☐Cancer ☐Other: _____

HAVE YOU HAD SURGERY IN THE PAST? ☐NO ☐YES **TYPE/DATE:** _____
_____

FAMILY HISTORY: (CHECK ALL THAT APPLY) ☐HEART DISEASE ☐STROKE ☐ARTHRITIS ☐OSTEOPOROSIS ☐ALZHEIMER'S ☐GOUT ☐CANCER (TYPE) _____ OTHER: _____

DO YOU SMOKE/CHEW TOBACCO? ☐YES ☐NO __CIGARETTES _____PACKS/DAY __ CIGARS_____PER DAY

DO YOU USE RECREATIONAL DRUGS? ☐YES ☐NO IF YES, TYPE: _____

DO YOU DRINK ALCOHOLIC BEVERAGES? ☐YES ☐NO IF YES, HOW OFTEN? ☐SOCIALLY ☐RARELY ☐DAILY

HOW DID YOU HEAR ABOUT AFFINITY FAMILY CARE CLINIC? _____

FINANCIAL AGREEMENT

Payment is due in full at the time of service. Acceptable methods of payment are cash, debit and/or credit card.

I understand that my insurance policy is a contract between myself and my insurance company. If I have questions or concerns regarding my coverage for office visits, procedures, lab work, medications, or particular conditions, I am responsible for obtaining this information. I agree to pay all copayments and/or coinsurance, deductibles as due in full for all services rendered if I choose to have the service provided.

HIPAA

Affinity Family Care Clinic upholds the standard of the HIPAA laws. As a patient, we want you to know:

- We respect the privacy of your personal medical records and will do all we can to secure and protect that privacy.
- When it is appropriate and necessary, we provide the minimum information to only those in need of your health care information, treatment, payment or health care operations, in order to provide health care that is in your best interest.
- You may refuse to consent to the use or disclosure of your personal health information, but *this must be in writing*.
- Under this law, we have the right to refuse to treat you should you refuse to disclose your Personal Health Information (PHI). This information is critical in making appropriate medical decisions.

If you have any questions regarding this consent, please speak with one of the staff of *Affinity Family Care Clinic*.

TREATMENT CONSENT AND AUTHORIZATION

I consent to medical screening and medical examination to determine my current health status, other medical evaluations, diagnostic procedures, routine care, and medical treatments which the medical and professional staff of *Affinity Family Care Clinic* may deem necessary, advisable, or appropriate. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of the procedures and/or treatments.

I have read the above information and consent that it is correct to the best of my knowledge. My signature here indicates compliance with the above policies.

_____ _____
Signature Date

Affinity Family Care Clinic

Affinity Family Care Clinic is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen. **Please call us at (210)247-2248 by 2:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 12:00 p.m. on Friday.** If prior notification is not given, you will be charged $25 for the missed appointment.

Please sign below to consent to these terms.

_____

Signature (Parent/Guardian if under 18)

_____

Date

Affinity Family Care Clinic

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize release of personal identified information, regarding the person named below, within the following specified limits:

1) Name: _____ SSN: _____ DOB: _____

2) Specific information to be released: _____

3) The purpose for which the information is to be released: _____

4) Organization/Address/Person to which this information is to be released:

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5) Organization/Address/Person releasing the information:
_____
_____
_____

6) The benefits, risks, and consequences of the alternatives in releasing or not releasing this information have been explained to me:
Yes ☐ No ☐

7) If this released information contains any reference to any of the following (HIV, AIDS, STDs, TB) the release of that information is authorized: Yes ☐ No ☐

8) Unless otherwise specified below, this authorization will expire in ninety (90) days.
Date this authorization will expire: _____

9) I understand that I may revoke this authorization in writing at any time.

This information may not be further disclosed by the receiving person or organization without my authorization*
Authorization for Release of Above Information: *(*In order to be valid, this authorization must have the proper accompanying advisories and State and Federal citations.)

_____	_____	_____
Printed Name of Person Authorizing Release	Signature/Mark of Person Authorizing Release	Date

Advisories:

- You may refuse to sign the authorization to disclose some or all of your health care information, but you should be aware that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits, or other insurance or other adverse consequences.
- You may revoke this authorization at any time by a written revocation and by delivering it to the person or organization holding the release of information authorization. However, this revocation is subject to the right of any person who acted in reliance on the authorization prior to receiving notice of revocation.
- You are entitled to a copy of this authorization form.

For Persons/Organizations Receiving Substance Abuse Information:
This information has been disclosed to you from records protected by Federal confidentiality rules (*42 CFR Part 2*). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by *42 CFR Part 2.* A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. *(52 FR 21809, June 9, 1987; 52 FR 41997, November 2, 1987)*

For Persons/Organizations Receiving Mental Health Information:
This information has been disclosed to you from records protected by State confidentiality laws (*34-B M.R.S.A. Section 1207; Rights of Recipients of Mental Health Services*). This information remains confidential and should not be disclosed any further except as expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law.