
Patient Name: _____ DOB: _____

Marital Status: S M W D Sex: Male/Female SS#_____

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

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____

Ethnicity: _____ Race: _____ Language:_____

Employer Name & Address: _____

## Preferred Pharmacy

Pharmacy Name: _____ Address: _____

Phone: _____

## Emergency Contact

Name:_____Relationship:_____Phone: _____

Name:_____Relationship:_____Phone: _____

**Responsible Party-Minor ONLY**
**(only complete if under the age of 18)**

Who is responsible for payment for this patient?_____DOB: _____

Relationship to Patient:_____Phone: _____

## Insurance

Primary Insurance:_____Phone # _____

ID: _____ Group #: _____

Insured Name: _____ DOB: _____ Relation: _____

Secondary Insurance:_____ ID:_____ Group: _____

How Did You Hear About Us? _____

_____ _____ _____

Patient Signature Relation to Patient Date

# Patient History Form

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| ***Patient Name:*** | | | | | | | | |
| ***Date of Birth:*** | | | | | | | | |
| ***Social History:*** | **Married, Single or Divorced:** | | | | | | **Sexually Active:** | **Yes or no** |
| | | | | | | | | |
| **Current Smoker or Tabacco Use** | **Yes** | **No** | **Never** | **Type:** | | **# of yrs.** | | |
| **Current Alcohol Use** | **Yes** | **No** | **Never** | **Freq:** | | **Amount:** | | |
| ***Personal & Family History:*** | | | | **Maternal** | | **Paternal** | | |
| | **Self** | **Mom** | **Dad** | **Bro/Sis** | **GM** | **GF** | **GM** | **GF** |
| If deceased, list approx. age of | | | | | | | | |
| ***Neuro:*** | | | | | | | | |
| Migraines | | | | | | | | |
| Stroke | | | | | | | | |
| ***Mental Health:*** | | | | | | | | |
| Anxiety/Depression | | | | | | | | |
| Drug/Alcohol Abuse | | | | | | | | |
| ***ENT- Allergies*** | | | | | | | | |
| ***Endocrine:*** | | | | | | | | |
| Diabetes Type I or II | | | | | | | | |
| Thyroid Disorder | | | | | | | | |
| ***Cardiovascular*** | | | | | | | | |
| High Blood Pressure | | | | | | | | |
| High Cholesterol | | | | | | | | |
| ***Resp- Asthma/COPD*** | | | | | | | | |
| ***GI- GERD/REFLUX/ULCER*** | | | | | | | | |
| ***Gynecology*** | | | | | | | | |
| Endometriosis/PCOS | | | | | | | | |
| ***Urology/Renal*** | | | | | | | | |
| Kidney Stones/disease | | | | | | | | |
| ***Cancers:*** | | | | | | | | |
| Breast Cancer | | | | | | | | |
| Colon Cancer | | | | | | | | |
| Prostate Cancer | | | | | | | | |
| Skin Cancer (type) | | | | | | | | |
| Other- | | | | | | | | |
| ***Viral History:*** | | | | | | | | |
| Hepatitis A, B or C | | | | | | | | |
| Ebstein Barr/ Mono | | | | | | | | |
| HSV I/HSV II | | | | | | | | |
| Other Viral/STD History | | | | | | | | |
| ***Other Medical Conditions:*** | | | | | | | | |

| | | |
|---|---|---|
| ***Ob/GYN History:*** | Last Menstrual Cycle: | Type Birth Control: |
| | Last Pap: | Last Mammo: |
| # of Pregnancies: | # of Vaginal Deliveries: | # of C-Sections: |
| ***Surgical History (list year & type)*** | | |

I certify the above information is correct to the best of my knowledge. I will not hold my provider or any staff member. responsible for any error or omissions that I may have made during the completion of this form.

| | |
|---|---|
| **Signature:** | **Date:** |

| **Drug Allergies & Reaction** | |
|---|---|
| | |
| | |
| | |
| | |

| **Current Medication List** | | |
|---|---|---|
| **Drug Name** | **Dose** | **Freq.** |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| **Current Supplement List** | | |
|---|---|---|
| **Supplement** | **Dose** | **Freq.** |
| | | |
| | | |
| | | |
| | | |
| | | |

| **Preferred Pharmacy** |
|---|
| |


# HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health InsurancePortability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient Name: _____ Date of Birth: _____

I authorize Family Focused Care and Health Fusion of Texas to use or disclose the following health information (check one)

☐ All my health information

☐ My health information relating to the following treatment or condition:

_____

☐ My health information covering the period from _____ (date) to _____ (date)

☐ Other: _____

**The above party may disclose this health information to the following recipient(s):**

| | Name | Relationship | Phone Number |
|---|---|---|---|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |

## If the patient is a minor, please complete the following

Patients Name: _____

Parent Name or Guardian: _____

Parent or Guardian Signature: _____ Date: _____

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party) and that I may have the right to refuse to sign this authorization.

Patient Name: _____ Patient Signature: _____ Date: _____