Celina Medical Clinic

Updated Patient Information

Please print clearly and complete all information requested.

Patient Last Name _____ **First Name** _____

Mailing Address _____ **City**_____ **State** _____ **Zip**_____

Home # _____ **Cell #** _____ **Work #** _____

DOB _____ **Sex:** M F **Marital Status:** M S D W

In case of emergency, please contact _____**Relationship** _____ **Phone** _____

Insurance Information

Insurance Name _____ **Policy Holder Name** _____**DOB**____/____/_____

Policy Holder's Mailing Address _____ **City**_____ **State** ____ **Zip**_____

Policy ID # _____ **Group #**_____

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

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 _____

Allergies: medications, food, other

Name: _____ ***Reaction:*** _____
Name: _____ ***Reaction:*** _____
Name: _____ ***Reaction:*** _____

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

Social History:

Tobacco use: (any form)	No Yes
Alcohol:	No Socially Yes
Drug use:	No Yes
Children:	___ # sons ___ # daughters
Occupation:	
Sexually active:	No Yes

Colonoscopy:	Date:

Patient Last Name _____ **First Name** _____ **Date of Birth** _____

Office Policies

As our patient, Celina Medical Clinic (CMC) 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 up-to-date and a current insurance card if filing with insurance today. CMC does not file with Medicaid or CHIPs and CMC does not file worker's compensation claims or motor vehicles accidents. Payment for all professional services is required 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. Any payment made to CMC will be applied to the oldest balance on file.

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 and we allow 72 hours to complete the forms. 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 _____

Celina Medical Clinic

Authorization of Use and Disclosure of Protected Health Information

Person(s) Authorized to Receive Information:

Any health information created or retained by Celina Medical Clinic, PLLC may be disclosed to the following person(s):

Name	Relation
Name	Relation
Name	Relation

Use and Disclosure of Information

_____I authorize the person(s) listed above to receive all health information such as dates of services, type of services, treatment, payment for healthcare and/or other pertinent information regarding my healthcare provided by Celina Medical Clinic.

_____I do not authorize Celina Medical Clinic to disclose my health information to any party other than those listed in the *Notice of Privacy Practices*.

*This authorization will not expire unless it is revoked in writing by the patient or the patient's legal guardian.

May we leave a message on an answering machine or voicemail regarding appointments, your treatment, or other information pertaining to your healthcare and/or payment for your healthcare provided by Celina Medical Clinic?

_____YES _____NO

If "NO" how may we contact you with this information?

_____

Signature of Patient or Legal Guardian	Relationship to Patient
Print Patients Name	Date

Print Name of Legal Guardian, if applicable