FLOWER MOUND FAMILY HEALTH CENTER
PATIENT REGISTRATION AND UPDATE FORM

HOW DID YOU HEAR ABOUT US? NEWSPAPER ____PHONE BOOK _____INTERNET____FRIEND ____

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Social Security: _____ Male/Female Marital Status: S/M/D/W

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

Home PH: _____ Cell PH: _____ Email Address: _____

Employer Name: _____ Work PH: _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Relationship to Patient: _____ Phone #: _____

PRIMARY INSURANCE INFORMATION
Relation to Guarantor: Self Spouse Child Other_____

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Social Security#: _____ Male / Female

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

Home PH: _____ Cell PH: _____

Employer Name: _____ Work PH#: _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

SECONDARY INSURANCE INFORMATION
Relation to Guarantor: Self Spouse Child Other_____

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Social Security#: _____ Male / Female

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

Home PH#: _____ Cell PH: _____

Employer Name: _____ Work PH#: _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

CONSENT TO TREATMENT

I HEARBY CONSENT TO EVALUATION, TESTING, AND TREATMENT AS DIRECTED BY FLOWER MOUND FAMILY HEALTH CENTER PHYSICIAN OR HIS/HER DESIGNEE.

ASSIGNMENT OF INSURANCE BENEFITS

I HEREBY AUTHORIZE DIRECT PAYMENT OF MY INSURANCE BENEFITS TO ROYA V. SEYSAN M.D... I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW MY INSURANCE BENEFITS. I UNDERSTAND AND AGREE THAT I WILL BE RESPONSIBLE FOR ANY CO-PAYMENTS OR BALANCES WHICH ARE DUE THAT THE PHYSICIAN IS UNABLE TO COLLECT FROM MY INSURANCE CARRIER.

SIGNATURE: _____ DATE: _____

Flower Mound Medical Center
2261 Olympia Dr., Suite 100
Flower Mound, TX 75028
Roya V. Seysan M.D.

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In effort to comply with the Health Information Privacy Act (HIPPA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and coworkers.

Please circle your response to the following:

May we leave messages concerning your **appointments** with a coworker, receptionist or secretary who regularly answers your calls? **Yes No N/A**

May we leave **messages** on a voicemail at home/cell phone/or work phone regarding an appointment, referral, or test results? **Yes No N/A**

May we **discuss** your appointments and/or treatment with your spouse? **Yes No N/A**

If you are over the age of 18, still living at home, may we discuss your appointments and/or treatment with your parent (s) or guardian? **Yes No N/ A**

If you are over the age of 18, may we discuss your **appointments and/or treatment** with your children? **Yes No N/A**

May we share your pertinent medical information with specialists that you may be seeing? **Yes No N/A**

May we release forms, prescriptions, or samples to your spouse or family members if they need to pick them up for you? **Yes No N/A**

Names of authorized person (s) receiving information:

Name: **Relationship:** **Phone Number:**

You must inform us, in writing, of any changes in your directives. This record will be kept in your file along with your acknowledgment of receipt of your Notice of Privacy Practices.

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

2261 Olympia Dr. Suite 100
Flower Mound, Texas 75028
(972) 691-8585 Fax: (972) 691-8686

FLOWER MOUND FAMILY HEALTH CENTER

FLOWER MOUND MEDICAL CENTER, LLC.

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

Signature:

I have received a copy and/or read the "Notice of Privacy Practices".

Name of Patient (Print)

Signature of Patient

Date of Signature

Signature of Patient Representative (Required if the patient is a minor or an adult who is unable to sign)

Relationship of Patient Representative to Patient

MEDICAL HISTORY FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ Date: _____

Address: _____ Occupation: _____

Home PH: _____Cell PH: _____ Date of Birth: _____Age: _____

Chief Complaint:

____

Drug Allergies: _____

Current Medications: _____

_____

Hospitalization or Surgery:

Reason	Date	Reason	Date

Family History: Place a check in all boxes that apply.

Disease	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart						
High Blood Pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/ Convulsions						
Bleeding Disorder						
Thyroid Disease						
Mental Illness						
Osteoporosis						

MEDICAL HISTORY FORM

Last Name: _____ First Name: _____

Medical History: Please check all that apply.

- Headache
- Shortness of breath
- Heart Palpitations
- Heart Murmur
- Chest Pain
- Dizziness/Fainting
- Peripheral vascular disease
- Allergies/Hay Fever
- Asthma
- Bronchitis
- Pneumonia
- Ulcer
- GI disorder
- Lactose Intolerance
- Gallbladder disease
- Prostate disease
- Bower irregularity
- Incontinence
- Sexual/Menstrual dysfunction
- Venereal disease
- Frequent infections
- Hepatitis
- Anemia
- Arthritis
- Osteoporosis
- Nervousness
- Depression
- Gout
- Scarlet fever
- Chronic rashes
- Rheumatic fever
- Mumps
- Measles
- Rubella
- Polio
- Diphtheria
- Tetanus
- Other
- Other

Women Only: Pregnant? o Yes o No Planning Pregnancy? o Yes o No

Men Only: It's common for men to occasionally experience erection difficulties.

Is this something that happens to you? o Yes o No

How often does this occur? o Frequently o Sometimes o Rarely

Habits:

o Smoke: Packs daily _____
How long? _____
Interested in stopping? __
o Exercise Routine: _____
_____
_____

o Coffee Cups daily_____
Other caffeine _____
o Alcohol Type_____
Amount _____
o Salt intake _____
o Fat intake _____

o Sleep: Difficulty falling asleep _____
Continuity disturbances_____
Snoring _____
Early morning awakening _____
Daytime drowsiness _____
Other _____

Flower Mound Family Health Center

Roya V. Seysan M.D.
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Financial Responsibility Agreement

Patient Name: ______________________________ Date of Birth_______________ Date of Visit: ______________

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any **Medical service or visit, Preventive Exam or Physical, Lab Testing, X-Ray, EKG, and any other Screening Service or Diagnostic Testing** ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the Physician or Clinic to know if my insurance will pay for **my Medical service or visit, Preventive Exam or Physical, Lab Testing, X-Ray, EKG,** or any **other Screening Service or Diagnostic Testing** ordered by the Physician or the physician's staff.

I understand and agree it is my responsibility to know if my insurance has any **Deductible, Co-Payment, Co-Insurance, Out-of-Network amount, Usual and Customary Limit**, or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out-of-pocket expense to me. I understand and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to know if my PCP choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company or plan, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

Signature: ____ Date: ____________________________

Responsible
Party Name: ____

Flower Mound Family Health Center
Roya V. Seysan, MD
2261 Olympia Dr. Suite 100
Flower Mound, Texas 75028
(972) 691-8585 Fax: (972) 691-8686

MEDICAL RELEASE of INFORMATION

Patient Name: _____

Date of Birth: _____ SS# _____

I hereby authorize:

Roya V. Seysan, M.D.
2261 Olympia Drive, Suite 100
Flower Mound, TX 75028

To release medical information on the above named patient to:

Physician name: _____

Phone: _____ Fax: _____

Please include:
____ All medical records
____ Lab/X-ray/MRI Reports
____ Immunization Records
____ Other _____

Signature _____ Date _____

Relationship to Patient _____

Prohibition on Redisclosure

This does not authorize redisclosure of medical information beyond the limits of this consent where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements 42 CFR Part 2 and state requirements Texas code prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil, and/or criminal penalties by attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

I understand that authorizing the disclosure of this health information is voluntary. If I have questions about disclosure of my health information I can contact the authorized individual or organization making disclosure.

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Consent for Treatment of a Minor

Please complete all information below: PLEASE PRINT.

Parent/Guardian Information:

Name _____ Address _____

Age ____ Phone _____ City/State/Zip _____

Minor Name: _____ DOB__/__/____ Relationship _____

Please check each box that applies from among the below:

1. Routine Care Yes/No
2. Immunizations Yes/No
3. Emergency Care Yes/No

I hereby authorize the medical care provider of Family Health Center to provide medical treatment to the minor specified above with or without my presence.

The authorization is to remain in effect: One year ____ or indefinitely _____.

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____