El Paso Primary Care

CARING FOR OUR COMMUNITY

Patient Registration Form

Patient Information

Last Name:	First Name: M.I.:	
Physical Address:	Mailing Address (if different than physical):	
City/State/Zip:	City/State/Zip:	
Cell Phone:	Home Phone:	Work Phone:
How Did You Hear About Us? ☐ Billboard/Sign ☐ Flyer ☐ Friend ☐ Google/Internet ☐ Dr. _____ ☐ Other:_____		
Referring Physician:	Date of Birth:	Gender:
Social Security #:	Emergency Contact Name:	
Emergency Contact Phone:	Relationship to Patient:	

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Insurance Company Name:	Insurance Company Name:
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

Additional Information

Email Address:

Race

☐ African American ☐ Asian ☐ White ☐ Decline to Report ☐ Other:_____

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Report ☐ Other: _____

Preferred Language

☐ English ☐ Spanish ☐ Other: _____

Would you prefer appointment reminders via text or voice call? ☐ Text ☐ Voice

What is your preferred phone number to receive reminders? ☐ Cell Phone ☐ Home Phone

Preferred Pharmacy & Location:

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Patient Name:
Date of Birth:
Date of Visit:

Please list all medications you take, including over-the-counter (OTC) medications and vitamins. / Enumere todos los medicamentos que toma, incluidos los de venta libre y vitaminas.

Medication Name / Nombre del Medicamento	Dose / Dosis	Times Per Day / Veces por Dia

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Patient Name:
Date of Birth:
Date of Visit:

Please ☑ Check All That Apply

	Allergies, Seasonal				Joint Pains
	Anemia		Eye Problems		Macular Degeneration
	Anxiety		GERD		Neuropathy
	Arrhythmia		GI Issues		Osteopenia/Osteoporosis
	Asthma		Glaucoma		Parkinson's Disease
	Back Pain		Gynecologic Issues		Psoriasis
	Bipolar Disorder		Headaches		Pulmonary Embolism
	Bladder		Hearing Issues		Rheumatoid Arthritis
	Bleeding Problems		Heart Attack		Seizure Disorders
	Cancer: _____		Heart Disease		Sleep Apnea
	COPD/Emphysema		Hepatitis		Stroke
	Crohn's Disease		Hernia		Thyroid Disorder
	Dementia		High Blood Pressure		Ulcerative Colitis
	Depression		High Cholesterol		
	Diabetes, Type I		HIV		
	Diabetes, Type II		Irritable Bowel Syndrome		
	Diverticulitis		Kidney Disease		
	Erectile Dysfunction		Kidney Stones		
Other Medical Problems: _____					

Check All That Apply

☐	Procedures / Screening	Date of Procedure / Screening	Status
	Colonoscopy		Normal / Abnormal
	Dexa (Bone Density)		Normal / Abnormal
	FOBT		Normal / Abnormal
	Mammogram		Normal / Abnormal
	Pap		Normal / Abnormal
	TB Test		Normal / Abnormal

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Date of Visit:

Food / Medication Allergies	
☐ No Known Food Allergies	☐ No Known Drug Allergies
Type of Allergy	**Reaction**

Surgical History	
Type of Surgery	**Date**

Recent Hospitalizations		
Hospital	**Date**	**Reason**

Vaccination History	
Type of Vaccination	**Date**
Last Tetanus Booster or Tdap	
Last Flu Vaccine	
Last Zoster Vaccine (Shingles)	
Last PneumoniaVaccine	

Women's Health History	
First Day of Last Menstrual Cycle:	Age of First Menstruation:
Age of Menopause:	Total Number of Pregnancies:
Number of Live Births:	
Pregnancy Complications:	

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Date of Birth:	
Date of Visit:	

Family History

☐ No Significant Family History is Known

Condition	Mother	Father	Maternal Grandparent	Paternal Grandparent	Sibling	Child
Cancer: _____						
Diabetes						
Early Death						
Heart Disease						
Hypertension						
Psychiatric Disorder						
Stroke						

Social History

Highest level of eductation completed?	☐ Elementary ☐ Middle School ☐ High School ☐ GED ☐ Technical School ☐ Associate's Degree ☐ Bachelor's Degree ☐ Post Graduate Degree	
	Circle	**If Yes, Please Provide Additional Details**
Are you currently employed?	Yes / No	☐ Retired (List Previous Occupation Below) ☐ Disabled ☐ Current Occupation: _____
Do you have children?	Yes / No	How Many?
Are you married?	Yes / No	
Are you sexually active?	Yes / No	
Do you drink caffeine?	Yes / No	Occassionally 1-2 cups daily 3+ cups daily
Do you exercise?	Yes / No	What Kind of Exercise / How Often:
In the last year have you consumed alcohol?	Yes / No	☐ Less Than Monthly ☐ 2 - 3 Times a Week ☐ 2 - 4 Times a Month ☐ 4+ Times a Week
Have you ever used illicit drugs?	Yes / No	☐ Current User ☐ Former User
Do you use tobacco products? (including e-cigarettes)	Yes / No	If Yes, Please Provide Additional Details
How soon after you wake do you have a tobacco product?		☐ Within 1 Hour of Waking ☐ Longer Than 1 Hour After Waking
How many tobacco products do you consume in a day on average?		☐ 5 or Less ☐ 6-10 ☐ 11-20 ☐ 21 or More
Are you interested in quiting?		☐ Yes ☐ No

Please Flip Over to Continue

Alcohol Questionnaire	
Have you ever felt you should cut down on your drinking?	Yes / No
Have people annoyed you by criticizing your drinking?	Yes / No
Have you ever felt bad or guilty about your drinking?	Yes / No
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?	Yes / No

Drug Questionnaire	
Have you ever felt you ought to cut down on your drug use?	Yes / No
Have people annoyed you by criticizing your drug use?	Yes / No
Have you felt bad or guilty about your drug use?	Yes / No
Have you ever used drugs first thing in the morning to steady your nerves?	Yes / No

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Date of Birth:	
Date of Visit:	

Please ✓Check All That Apply

	CONSTITUTIONAL		RESPIRATORY		MUSCULOSKELETAL
	Appetite Change		Chest Congestion		Back Pain
	Chills		Choking		Walking Problems
	Excessive Sweating		Cough		Joint Symptoms
	Fatigue		Shortness of Breath		Muscle Pain
	Fever		Noisy Breathing		Neck Pain
	Insomnia		Wheezing		Neck Stiffness
	Unexpected Weight Change		**GASTROINTESTINAL**		**SKIN**
	Weakness		Abdominal Distention		Color Change
	HEENT		Abdominal Pain		Hives
	Congestion		Blood in Stool		Itching
	Dental Problem		Constipation		Lesions
	Drooling		Diarrhea		Lumps
	Ear Discharge		Nausea		Open Wounds
	Ear Pain		Rectal Bleeding		Rash
	Eye Discharge		Rectal Pain		Warts
	Eye Itching		Vomiting		**NEUROLOGICAL**
	Eye Pain		**FEMALE REPRODUCTIVE**		Coordination Issues
	Eye Redness		Vaginal Discharge		Difficulty Walking
	Facial Swelling		Breast Symptoms		Dizziness
	Hearing Loss		Abnormal Periods		Fainting
	Light Sensitivity		Post Menopausal Symptoms		Headache
	Mouth Sores		Pregnant		Light Headedness
	Nosebleeds		**MALE REPRODUCTIVE**		Loss of Sensation
	Postnasal Drip		Diminished Sexual Drive		Memory Loss
	Ringing in Ears		Erectile Dysfunction		Numbness
	Runny Nose		Penile Discharge		Seizures
	Sinus Drip		Penile Pain		Speech Difficulty
	Sneezing		Scrotal Swelling		Tingling
	Sore Throat		Testicular Pain		Tremor
	Trouble Swallowing		**URINARY**		**PSYCHIATRIC**
	Visual Disturbance		Blood in Urine		Agitation
	Voice Change		Change in Frequency		Confusion
	CARDIOVASCULAR		Difficulty Urinating		Decreased Concentration
	Chest Pain		Flank Pain		Hallucinations
	Chest Pressure		Genital Sore		Hearing Voices
	Irregular Heart Beat		Painful Urination		Hyperactive
	Leg Swelling		Urgency		Nervous/Anxious
	Palpitations		Urinary Incontinence		Self-Injury
	HEMATOLOGIC		Urine Decreased		Sleep Disturbances
	Bleeds Easily		**ENDOCRINE**		Suicidal Ideas
	Bruises Easily		Cold / Heat Intolerance		Other Concerns:
			Excessive Thirst		
			Increased Appetite		
			Frequent Urination		

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Date of Visit:	

PATIENT HEALTH QUESTIONNAIRE (PHQ-2)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(please circle your answers)

	Not at All	**Several Days**	**More Than Half the Days**	**Nearly Everyday**
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				

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Date of Visit:	

FINANCIAL RESPONSIBILITY

We charge what is usual and customary for our area of practice.

1. Full private payment or insurance co-pays/co-insurance and/or deductible for office visits, labs, urine drug screens, and/or any other service provided within El Paso Primary Care Associates are due at the time of service. Furthermore, account balances are due at the time of service unless prior arrangements have been made.

Initial_____

2. If I know I will be unable to make my appointment, I will notify the El Paso Primary Care Associates as soon as possible. **I understand that cancellations must be made at least 24 hours before the scheduled appointment or I will be charged $25. This fee is not charged to your insurance company.**

Initial_____

3. Please note we only bill insurance companies that we are contracted with. Furthermore, it is your responsibility to follow up with the insurance company to ensure the claim is paid within 60 days of the date of service. We must emphasize that as healthcare providers, our relationship is with you, our patient, and NOT with your insurance company. You are responsible for knowing what your insurance benefits are, including what your insurance will and will not pay for; and how to access your benefits, including obtaining referrals, etc. If you are unsure please contact your insurance carrier. This office assumes no responsibility for your lack of knowledge regarding your insurance benefits. **You are responsible for any remaining unpaid charge(s) as determined by your insurance company regardless of cause.**

Initial_____

This agreement is necessary in order to accept your insurance without having to bill you upfront. An account past due 90 days or more and payment plans that are not kept current, may be subject to collection and associated fees. By signing the agreement below, you assign insurance benefits to be paid directly to El Paso Primary Care Associates. You also authorize El Paso Primary Care Associates to release any information which may be needed for processing of all claims; certification/ case management/ quality improvement; and/or other purposes related to the benefits of your health plan. Furthermore, understand that it is your responsibility to ensure that proper referrals or authorizations are obtained for each visit. **Finally, we require notification of insurance changes at least one week prior to your scheduled appointment to avoid appointment delays and/or private pay expenses.**

By signing below, you are stating that you understand and agree to all of the above.

Patient Signature: _____ Date: _____

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Name: _____ DOB: _____

HIPAA ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS

By signing below, I acknowledge that I have read and understand El Paso Primary Care Associates's Notice of Privacy Practices. Upon my request I can be provided a copy for my records.

I consent to the use and disclosure of my medical information as set forth herein, except as expressly stated below. I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

Patient Signature: _____ Date: _____

HIPAA PRIVACY AUTHORIZATION FORM

☐ **I authorize El Paso Primary Care Associates to use and/or disclose the Protected Health Information (PHI) selected below:**

Name	DOB	Prescriptions Pick Up Only	All PHI*
_____	_____	☐	☐
_____	_____	☐	☐
_____	_____	☐	☐

pick up and all other purposes as I may direct.

This authorization is valid for the following:
☐ All past, present, and future appointments.
OR
☐ Only from _____ to _____
Date Date
☐ I do not authorize the use and/or disclosure of my Protected Health Information.

I understand that I have the right to revoke this authorization, in writing at any time.

Patient Signature: _____ Date: _____

Name: _____ DOB: _____

PATIENT EDUCATION: SUICIDE RISK PREVENTION

AN IMPORTANT MESSAGE TO THE PATIENT AND/OR PATIENT'S LOVED ONES

If you or a loved one notice these warning signs listed below, seek help **immediately** and/or call one of thr available suicide telephone hotlines listed below. Please know that if you hve access to firearms or know your loved one has access to firearms, it is important to secure those safely away from reach NOW.

TWO (2) telephone numbers are provided for you today. One number is a national toll-free Suicide Prevention Hotline that is available 24 hours per day, 7 days per week.

- **Suicide Prevention Lifeline: 1-800-273-TALK (8255).** This national crisis hotline number serves English and Spanish speaking callers
- **El Paso Crisis Hotline: (915) 593-7300**

Please Initial the Following Statements

_____ I understand that driving can be dangerous if I am not fully alert and oriented and I will not drive if I feel impared.

_____ I understand that managing my medications may be difficult if I am distracted, angry, or confused and I will ask for help with managing my medications if needed.

_____ I understand that it is important that I am not alone and I will call one of the numbers above if I am feeling lonely, unsafe, or need someone to talk to.

_____ I understand that I should not use drugs, alcohol, or medication not currently prescribed to me in any other way than how my doctor has prescribed them to me.

Suicide risks and warning signs- Please call for help IMMEDIATELY if you experience any of the following warning signs:

* Seeking access to guns, pills, or other potentially harmful items or substances
* Talking or writing about death/dying or suicide when out of the ordinary
*Feeling of hopelessness
* Acting recklessly
* Feeling trapped as if there is no way out
* Increasing alcohol or drug use
* Withdrawl from family and friends
* Feeling anxious, agitated, unable to sleep or sleeping all of the time
* Dramatic Mood chabges
* Seeing no reason for living or having no sense of purpose in life
* Giving away possessions to others that are of importance to the individual
* Cutting one's self or exhibiting other self-destructive or self-harming actions.

I ave received my suicide risk preention education above and I understand it's contents and my duties in regards to the information provided. I have had my questions answered to my satisfaction.

Patient Signature: _____ Date: _____

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Name: _____ DOB: _____

RELEASE OF MEDICAL RECORDS AUTHORIZATION

I authorize the custodian of records to release the following:

☐ My medical records, including but not limited to; office visit notes, all imaging and all laboratory reports.

List any additional records or provide any restrictions on records to be forwarded:

_____

_____

_____

Please fax or mail indicated records to:

Fax:
(915) 500-6090

El Paso Primary Care Associates
4545 N. Mesa St.
El Paso, TX 79912

This information may be used/disclosed for the purpose of my healthcare.

Patient Signature: _____ Date: _____

El Paso Primary Care
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Name: _____ DOB: _____

CONSENT TO LABORATORY TESTING & USE OF RESULTS

In consideration of services rendered, I transfer and assign any benefits of insurance to El Paso Primary Care Associates and it's affiliates (known collectively hereafter as EPPCA) and authorize EPPCA to submit claims on my behalf directly to my health insurance provider/ plan. I acknowledge that EPPCA may submit laboratory specimens to a licensed reference laboratory to perform testing. I authorize EPPCA to release to my insurance carrier, or any health plan of which I am a member, any medical information needed for claim processing. I understand that EPPCA may be an out of network provider and my practitioner may hold an ownership interest in this laboratory, and as such, may receive a return of investment from this interest. I understand that I have the option of obtaining lab services from another facility and that upon my request will be provided a list of alternative laboratory facilities. I understand that if the insurance company pays me directly for services rendered by EPPCA, I am responsible to forward the payment to EPPCA. I agree that this Consent to Testing & Use of Results will cover all medical services rendered by EPPCA to me until such authorization is revoked in writing by me.

Patient Signature: _____ Date: _____

PHYSICIAN DISCLOSURE

As required by Section 102.006 of the Texas Occupation Code

Texas law requires a physician to disclose to a patient those arrangements permitted under applicable Texas law whereby such physician accepts remuneration to secure or solicit a patient or patronage for a person licensed, certified or registered by a Texas health care regulatory agency. The purpose of this Disclosure is to notify you, the patient, that your attending physician(s) may receive remuneration for referring you to certain diagnostic testing laboratories, pharmacies and/or other ancillary healthcare providers, for certain toxicology and pharmacogenetic testing services, compounding pharmacy products, diagnostic imaging services and other ancillary healthcare service, including but not limited to Gateway Surgical Center, El Paso Pain Center Pharmacy, and El Paso Pain Center Laboratories.

Accordingly, I hereby acknowledge that my attending physician(s) have disclosed to me, at the time of initial contact and at the time of referral (i) his or her affiliation, if any, with the diagnostic testing laboratory, pharmacy or other ancillary healthcare provider for whom, I, the patient am being referred, and (ii) that he/she will receive, directly or indirectly, remuneration for the referral to such diagnostic testing laboratory, pharmacy or other ancillary healthcare provider. I understand that I, the patient, have the right to choose the providers of my health care services and/or products and, as such, I have the option of receiving ancillary healthcare services from any ancillary healthcare provider and/or facility that I choose.

Patient Signature: _____ Date: _____

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Name: _____ DOB: _____

AGREEMENT AS TO GOVERNING LAW AND FORUM

The patient or the patient's representative and health care provider, including employees and agents of the health care provider, rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree: (1) that all health care rendered shall be governed exclusively and only by Texas Law and in no event shall the law of any other state apply to any health care rendered to patient; and (2) in the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall only be brought in a Texas Court in the county/district where all or substantially all of the health care was provided or rendered and in no event will any lawsuit, action, or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.

Patient Signature: _____ Date: _____

ACUERDO SOBRE LA LEGISLACION VIGENTE Y FORO

El paciente o el representante del paciente y el proveedor de atención médica, incluidos los empleados y los agentes del proveedor de atención médica, prestando o proporciona atención médica, cuidado de salud o seguridad o profesionales o servicios administrativos directamente relacionados con la atención médica a pacientes acuerdan: (1) que toda la atención medica prestada se regirá exclusivamente y únicamente por la ley de Texas y en ningún caso la ley de ningún otro estado se aplicara a la atención medica que se brinda al paciente; y (2) en el caso de una disputa, cualquier demanda, acción o cause relacionada de alguna manera con la atención médica proporcionada al paciente solo se llevara a un tribunal de Texas en el condado/distrito donde se brindó o presto la totalidad o sustancialmente toda la atención y en ningún caso se prestara ninguna demanda, acción o cause de acción en ningún otro estado. La elección de la ley y las disposiciones de selección de foro de este párrafo son obligatorias y no son permisivas.

Firma del Paciente: _____ Fecha: _____