KELLY FAMILY CLINIC
Family Medicine & Obstetrics

## PATIENT INFORMATION

Name:_____ _____Date of Birth _____

Address:_____City:_____State:_____Zip_____

Primary Phone (_____)_____ Secondary Phone (_____) _____ Other Phone (____)_____

SS# _____-____-_____ Email address_____

Race_____ Ethnicity _____ Preferred language _____

Marital Status ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Person to contact in case of emergency_____ Phone_____ Relationship_____

Preferred pharmacy _____ Location: _____

How did you hear about us? _____

## INSURANCE INFORMATION

Name of Insured (if other than self)_____DOB_____

Insured SSN#:_____ Relationship to Patient _____

**Financial Responsibility/Assignment of Benefits**

As a courtesy to you, our office will file insurance for all reimbursable services to both your primary and secondary insurance carriers. While we do our best to accurately predict your insurance coverage, sometimes our estimates are inaccurate due to circumstances beyond our control. Should your insurance not pay as we expect, or does not pay in a timely manner, you will be responsible for the unpaid portion of your charges.

I assign to C. Kelly Family Clinic, PA, any insurance, or other third party benefits available for health care services provided to me. I understand that C. Kelly Family Clinic, PA has the right to refuse or accept assignment of such benefits.

I have been given the opportunity to read the clinic's patient policies and procedures. The policies are available upon request.

Signature of Patient or Responsible Party _____ Date _____

## HIPAA INFORMATION

Protected health information (PHI) will only be released from our practice with a properly executed authorization from the patient or his/her personal representative, except for treatment, payment, or health care operations and as otherwise required by law. Examples of some instances in which we are required to disclose your PHI include: Public health activities; information regarding victims of abuse, neglect, or domestic violence; health oversight activities; judicial and administrative proceedings; law enforcement purposes; organ donations purposes; research purposes under certain circumstances; national security and intelligence; and correctional institutions. **C. Kelly Family Clinic, PA** will only use or disclose PHI, except as noted above, consistent with the terms of the authorization.

I understand that I have the right to review the notice of Privacy Practices that provides a more complete description of information uses and disclosures.

Kelly Family Clinic may share my PHI with the following additional person(s): _____

Signature_____ Date _____

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## Past Medical History

- ☐ **None**
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Blood Clot
- ☐ Blood Transfusion
- ☐ Cancer
  What kind?_____
- ☐ Chicken Pox
- ☐ Colon Polyps
- ☐ Crohn's Disease or IBS
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Eczema
- ☐ Frequent UTI's
- ☐ Frequent Sinus Infections
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Condition Specify_____
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Kidney Infections
- ☐ Kidney Stones
- ☐ Migraines
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Prostate Problems
- ☐ Psoriasis
- ☐ Reflux (Heartburn)
- ☐ Rheumatoid Arthritis
- ☐ Rosacea
- ☐ Seizures
- ☐ STD
- ☐ Stomach Ulcers
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcerative Colitis
- ☐ Warts
- ☐ Other:_____

## Surgical History

| | Year |
|---|---|
| ☐ Appendectomy | _____ |
| ☐ Back Surgery | _____ |
| ☐ Cataract Surgery | _____ |
| ☐ Cesarean Section | _____ |
| ☐ Gallbladder Surgery | _____ |
| ☐ Heart Surgery | |
| Specify_____ | |
| ☐ Hemorrhoid Surgery | _____ |
| ☐ Hernia | _____ |
| ☐ Hysterectomy | _____ |
| ☐ Joint Surgery_____ | _____ |
| _____ | _____ |
| ☐ Lumpectomy | _____ |
| ☐ Plastic Surgery | _____ |
| ☐ Polyp Removal (Colon) | _____ |
| ☐ Tonsillectomy/Adenoidectomy | _____ |
| ☐ Tubal Ligation or Vasectomy | _____ |
| ☐ Other | |

☐ **None**

## Family History

| Family History | Grandparent | Sibling | Mother | Father |
|---|---|---|---|---|
| ☐ Heart Disease/Attack | ☐ | ☐ | ☐ | ☐ |
| ☐ Stroke | ☐ | ☐ | ☐ | ☐ |
| ☐ Diabetes | ☐ | ☐ | ☐ | ☐ |
| ☐ High Blood Pressure | ☐ | ☐ | ☐ | ☐ |
| ☐ High Cholesterol | ☐ | ☐ | ☐ | ☐ |
| ☐ Hypothyroidism | ☐ | ☐ | ☐ | ☐ |
| ☐ Depression | ☐ | ☐ | ☐ | ☐ |
| ☐ Asthma | ☐ | ☐ | ☐ | ☐ |
| ☐ Osteoporosis | ☐ | ☐ | ☐ | ☐ |
| ☐ Migraines | ☐ | ☐ | ☐ | ☐ |
| ☐ Other Illness:_____ | ☐ | ☐ | ☐ | ☐ |
| ☐ Colon Cancer | ☐ | ☐ | ☐ | ☐ |
| ☐ Prostate Cancer | ☐ | ☐ | ☐ | ☐ |
| ☐ Lung Cancer | ☐ | ☐ | ☐ | ☐ |
| ☐ Breast Cancer | ☐ | ☐ | ☐ | ☐ |
| ☐ Uterine Cancer | ☐ | ☐ | ☐ | ☐ |
| ☐ Ovarian Cancer | ☐ | ☐ | ☐ | ☐ |
| ☐ Skin Cancer | ☐ | ☐ | ☐ | ☐ |
| ☐ Other Cancer:_____ | ☐ | ☐ | ☐ | ☐ |

## Mental Health History

- ☐ ADD/ADHD
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Eating Disorder
- ☐ Sleep Disorder

☐ **None**

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## Social History

Highest Level of Education: ☐ Less than 8th grade ☐ Less than High School ☐ High School ☐ College ☐ Graduate school ☐ Professional

What type of work do you do? _____

Are you sexually involved? ☐ Yes ☐ No

If you have any children, please list their names and ages: _____

_____

What hobbies or activities do you enjoy? _____

Do you exercise? ☐ Yes ☐ No If so, what type and how often?_____

Do you have a living will? (Do not resuscitate or medical power of attorney) ☐ Yes ☐ No

Is there concern for your safety? (Emotional, physical, or sexual abuse) ☐ Yes ☐ No

### Tobacco Use

☐ Never Smoked
☐ Ex-Smoker Quit Date_____
☐ Current Smoker
☐ Current Smoke Exposure
☐ Smokeless tobacco use

### Caffeine/Alcohol Use

**Alcohol**
☐ None
☐ 2 or less/day
☐ 3 or more/day

**Caffeine**
☐ None
☐ 3 or less/day
☐ 4 or more/day

☐ History of problems with alcohol

### Street Drug Use

☐ Never Used Street Drugs
☐ Past Use
☐ Current Use

## Current Medications

Include Over the counter medications and food supplements. Continue on back page if needed. If you do not take medications, please check "None." ☐ **None**

| **Medication Name** | **Dose** | **How Often** |
|---|---|---|
| | | |
| | | |
| | | |

## Medication Allergies

Include any medication to which you have had a reaction. ☐ **None**

| **Medication Name** | **Reaction** |
|---|---|
| | |
| | |
| | |

KELLY FAMILY CLINIC
Family Medicine & Obstetrics 794 Generations Dr., Ste. 100 New Braunfels, TX 78130 (830)214-6411 www.kellyfamilyclinic.com

# Authorization to Release Medical Records

I authorize my prior physician,_____, to release my ENTIRE medical records to Kelly Family Clinic.

**My prior physician's information:**

Phone:_____

Fax:_____

**My information:**

Patient's Name:_____

Date of Birth:_____

This information is to be disclosed by either fax or mail to:

**Kelly Family Clinic**
**794 Generations Drive, Suite 100**
**New Braunfels, TX 78130**
Phone: 830-214-6411
Fax: 830-626-8800

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*I authorize the release of my entire medical record to Kelly Family Clinic in order to transfer care. I understand my medical record may contain sensitive information such as mental health, HIV, AIDS, substance abuse, sexual abuse and/or other related conditions.*

I understand that I may withdraw or revoke this permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying Kelly Family Clinic in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by the Federal of Texas privacy regulation.

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization if requested. A photocopy of this authorization is as valid as the original.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Printed name

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# Physician Assistant Consent for Treatment

This facility has on staff a physician assistant to assist in the delivery of medical care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the Texas Medical Board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of, and accepting responsibility for the medical services provided.

A physician assistant may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulation a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above, and hereby consent to the services of a physician assistant for my health care needs.

I understand that at any time I can refuse to see the physician assistant and request to see a physician.

_____ _____

Signature Date