1: Patient Information

Name: ______________________________________ Birth Date:____________________

Preferred First Name:______________ Gender:_________SSN:______________________

Home Address:____

City:_____________________________ State: ________________ Zip: _______________

Home Phone: _________________________Mobile Phone: ________________________

Work Phone:_____________________ Email: ___________________________________

Please *circle* your preferred communication for reminders: phone | text

Does our system have consent to call the number on file? (*circle*) yes | no

How did you hear about us? ____

Preferred Pharmacy (*name and location*):

____

2- Patient Portal

Would you like to have access to our patient portal? Yes | No

****If yes, an email address is <u>required</u> for a portal account. Additionally, please speak with our front desk staff to complete registration of the portal.**

3: Emergency Contact Information

Name: _________________________________Relationship: ______________________

Home Phone: _________________________

Mobile Phone: _________________________

4: Insurance Information

<u>Primary Insurance:</u>

Insurance Plan:____

Member ID:______________________________________

Group #:____________________

<u>Secondary Insurance:</u>

Insurance Plan:____

Member ID:______________________________________

Group #:____________________

****If you are not the policyholder of your insurance, please provide the following:**

Legal Name of Policyholder:___________________________ DOB:________________

SSN:________________________ Relationship to Policyholder: ___________________

Mercy Wellness Clinic Patient Authorization

Please read, initial, and sign below:

(Initial)_____**Credit Card on File:** I understand that by providing my current credit card information to Mercy Wellness Clinic that I am authorizing it to be charged for any balance remaining after all insurances on file have been billed and processed.

(Initial)_____**Assignment of Benefits:** I hereby authorize payment directly to Mercy Wellness Clinic, for medical benefits otherwise payable to me. I authorize my insurance company to disclose to Mercy Wellness Clinic, information regarding my insurance coverage, including, but not limited to verification of my examination and/or treatment to my insurance company and/or third-party payor.

(Initial)_____**Privacy Policy:** I acknowledge that I received, reviewed, and agree to comply with the Mercy Wellness Clinic Privacy Policy.

(Initial)_____**Consent to Treat:** I have the legal right to consent to medical and surgical treatment for myself. I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that the providers of Mercy Wellness Clinic believe are necessary for myself. I understand that by signing this form, I am giving permission to the doctors, nurses, and other healthcare providers to provide treatment for myself as long as I am a patient at Mercy Wellness Clinic.

(Initial)_____**E-Prescribing:** I voluntarily authorize Mercy Wellness Clinic to allow E-Prescribing for my prescription, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information, and medical dispense history so long as I am a patient at this office.

(Initial)_____**Recording/Photo Policy:** Mercy Wellness Clinic does not permit recording devices in the exam room or common areas. Our staff and other patients have the right to their image and likeness; therefore, we do not allow recordings or photos of any kind during the visit. I understand the policy and agree to comply.

(Initial)_____**Phone Messages:** I give my permission for Mercy Wellness Clinic to leave detailed phone messages when I am unable to answer the phone.

(Initial)_____**Annual Wellness/Physicals:** I understand that if I am here for an annual wellness exam/physical that it is covered by insurance. I understand that I may be billed for a regular office visit if I discuss other issues with the doctor that are not related to my annual physical.

(Initial)_____I understand I can withdraw my consent at any time by contacting Mercy Wellness Clinic in writing at 18568 Forty-Six Parkway, Spring Branch, TX 78070. Withdrawal may result in dismissal from the practice.

(Initial)_____I understand that if I do not cancel a scheduled appointment at least 24 hours in advance I will be subject to a $25 cancellation fee.

Patient/Parent/Guardian Name (Print):___________________________________
Patient/Parent/Guardian Signature:_______________________________________
Today's Date:_________________________

****Medical Release, <u>who is allowed access to your medical information (spouse, parent, grandparent, etc.)</u>****
I, _______________________________, *(your name)* give authorization for my healthcare information to be released to the following individual:
Persons Name:_______________________________________ Relationship:__________________________
Phone #::__________________________________

Persons Name:_______________________________________ Relationship:__________________________
Phone #::__________________________________

Signature:____ Date:___________________________________

Please provide answers to the following questions(*if applicable*):

When was your last Colonoscopy?
Month:___________ Year:______________

When was your last Bone Density Scan?
Month:___________ Year:______________

When was your last Mammogram?
Month:___________ Year:______________

When was your last Pap Smear?
Month:___________ Year:______________

When was your last Annual Exam?
Month:___________ Year:______________

When were your labs last drawn?
Month:___________ Year:______________

Please provide information regarding specialists you may see.

Specialist's Office Name	Specialist's Name	Phone #

Past Medical History?

____

____

____

____

Past Surgical History?

____

____

____

Family Medical History?

_Mother: ____

____

_Father: ____

____

_Sibling(*please specify either brother or sister*) ___________________________

____

Alcohol use? (*please circle*) Never / Former / Occasional / Frequent / Daily

(*If Applicable*) About how many days do you drink out of the week? _________

(*If Applicable*) About how many drinks per day? ___________

Tobacco Use? (*please circle*) Never / Former / Occasional / Frequent / Daily

(*If Applicable*) How many packs per day? _______________________________

(*If Applicable*) How long have you been smoking? ________________________

Allergies to medications? Y / N If yes, which medications?

____

Non-medication allergies? Y / N If yes, please include the severity

____

Any current medications:

Medication Name	Dosage	Frequency