

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 required 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

Primary Insurance:

Insurance Plan: _____

Member ID: _____

Group #: _____

Secondary Insurance:

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, who is allowed access to your medical information (spouse, parent, grandparent, etc.)****

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: _____

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