Louetta Family Medicine

5834 Louetta Road, Suite F

Spring, TX 77379

P: 832-698-4291 F: 832-698-4297

PATIENT'S NAME________________________DATE OF BIRTH___________SEX M F

ADDRESS______________________________HOME PHONE_____________________

CITY______________STATE____ZIP________WORK PHONE____________________

SOCIAL SECURITY # ______________________CELL PHONE_____________________

DRIVER LICENSE _________________________EMAIL ___________________________

PATIENT EMPLOYER ____

PRIMARY INSURANCE____

POLICY HOLDER NAME / DATE OF BIRTH __________________________________

RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

PERSON TO NOTIFY IN CASE OF EMERGENCY _____________________________

RELATIONSHIP_______________________ PHONE # ____________________________

HOW DID YOU HEAR ABOUT US? ____

We ask that all patients show their insurance card with identification card and allow us to make a copy for our records.

I hereby authorize LOUETTA FAMILY MEDICINE, P.A. to furnish information to insurance carriers concerning my illness and treatments. I hereby assign LOUETTA FAMILY MEDICINE, P.A. all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. Furthermore, I give consent to be treated by the physician/staff at LOUETTA FAMILY MEDICINE, P.A.

Signature:______________________________________ **DATE:**____________________

To Our Valued Patients: Our goal is to provide quality medical services for our patients. We will strive to direct your care and your need for specialist consults, lab work, and other test according to your managed care guidelines. However, our office deals with many different plans, and it is the patient's responsibility to make sure that all facilities and specialists that we recommend you to are on our health care plan. Please verify their participation **BEFORE** services rendered to receive network benefits from your insurance company.

Louetta Family Medicine
Adult New Patient Form

Name:____ Date of Birth:__________

Reason for visit today ____

DEPRESSION SCREENING: Please answer how you have felt in the last 2 weeks

	Not at all	Several days	Over half the days	Nearly every day
LESS THAN normal interest or pleasure in doing things?				
Feeling down, depressed, or hopeless?				

DRUG ALLERGIES: (list medication name and type of reaction):______________________________

MEDICATION REVIEW: ☐ Not taking medications

Medication Name	Reason for taking	Dosage	Directions

PAST MEDICAL HISTORY:

❑ Check here if you have NO medical problems

CHECK BOXES BELOW IF YOU HAVE BEEN TOLD YOU HAVE:

- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Heart disease
  - ❑ irregular beat
  - ❑ heart failure
  - ❑ blockage of arteries
- ❑ High cholesterol
- ❑ Stroke
- ❑ Migraine
- ❑ Glaucoma
- ❑ Alzheimer's/Dementia
- ❑ Cancer (type/year)________
- ❑ Asthma
- ❑ Emphysema/ COPD
- ❑ Thyroid disorder
  - ❑ hypothyroid
  - ❑ hyperthyroid
  - ❑ thyroid nodules
- ❑ Hepatitis/ Cirrhosis
- ❑ Reflux/ulcers
- ❑ Sleep apnea
- ❑ Osteoporosis
- ❑ Arthritis
- ❑ Other________________
- ❑ Anemia
- ❑ Alcoholism
- ❑ Mental illness
  - ❑ anxiety
  - ❑ depression
  - ❑ bipolar
- ❑ Kidney disease
- ❑ Frequent UTI's
- ❑ Overactive bladder
- ❑ Prostate problems

Surgeries (Type and Year) ☐ None

1.________________________________
2.________________________________
3.________________________________
4.________________________________
5.________________________________

Hospitalization (Reason and Year) ☐ None

1.________________________________
2.________________________________
3.________________________________
4.________________________________
5.________________________________

FAMILY MEDICAL HISTORY Please mark the appropriate boxes below

	Diabetes	High Blood pressure	Heart Disease	High Cholesterol	Stroke	Mental Illness	Cancer (type)	Other	Unknown
Father									
Mother									
Pat. Grandfather									
Pat. Grandmother									
Mat.Grandfather									
Mat.Grandmother									
Siblings									

SOCIAL HISTORY:

Occupation:	Marital status:	Children (ages):

Tobacco Use	Alcohol Use	Caffeine Intake	Drug Use	Exercise
❑ None	❑ None	❑ None	❑ None	❑ None
_____ cigs per day	_____ per day	____ amount per day	_____ type	____ hours per day
_____# years used	_____ type	____ type	_____ last used	____ times per week
_____ years quit	_____ years quit			

SEXUAL HISTORY:

Number of partners in the last one year_____ Sexually active with:(please circle) Males Females Both None

VACCINE HISTORY:

Last Tetanus/whooping cough:_______ Last Flu:________ Last Pneumonia:________ Last Shingles:________

WOMEN ONLY

Birth Control Method:________________ Pregnant:___________________ Breastfeeding:__________________
Last period:_________________________ Days between the start of each period: __________________
Number of pregnancies:______________ Number of deliveries:_______________________

PREVENTATIVE CARE

	Month	Year	Result	Where/Who?
Eye exam				
Mammogram (female)				
Pap smear (female)				
Bone Density				
Colonoscopy				
Prostate (male)				

Pharmacy Name and Phone Number:____
Print Name____
Patient Signature: Date:

Due to updated guidelines per Insurance plans

Please choose one of the following:

Race:

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian or other Pacific
- ☐ Black or African American
- ☐ White
- ☐ Hispanic
- ☐ Other Race
- ☐ Other Pacific Islander
- ☐ Unreported/Refused to Report

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic
- ☐ Refused to Report

Language:

- ☐ English
- ☐ Other
- ☐ Indian
- ☐ Spanish
- ☐ Russian

How would you like appointment reminders?

- ☐ Voice Mail
- ☐ Text Message

Preferred Phone Number ______________________________

Preferred time to call: **Morning** **Afternoon** **Evening**

Would you like to have access to our Patient Portal (Informational Website) if YES please provide

email: ____

____

Patient's Signature **Date**

Health Disclosure Information

I, ______________________________ will allow Louetta Family Medicine to disclose information to the following person(s) about my health, If I am not available. I also will allow them to bring my minor children in my absence.

Acknowledgement of review of Notice of Privacy Practices

I can be offered a copy to review of Louetta Family Medicine, P.A.'s Notice of Privacy Practices, which explains how my medical information will be used and disclosed. Please ask for your copy at time of check in if desired.

Name:	Relationship:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

______________________________	______________________________
Signature of Patient or Personal Representative	Date

Office & Financial Policies

We are committed to providing you with the highest quality medical care in an efficient, timely, and cost-effect manner. We provide you with our policies in advance to prevent any misunderstandings or frustration at the time of your visit. PLEASE INITIAL EACH SLOT ACCORDINGLY.

______INSURANCE: **you are responsible** for knowing your insurance benefits and if you have a deductible or co-pay plan. **HMO policies must have one of our doctors designated as their physician prior to being seen.** If this change is not done prior to the appointment you may be asked to reschedule or pay out of pocket for the visit. We will not become involved in disputes between you and your insurance company regarding your coverage/policy benefits. **You are responsible** for timely payment on your account. **Bring your insurance card to every appointment.** Without your card we are unable to file for your visit and you will be responsible for the cost of the visit.

______CAR ACCIDENTS: we do not bill or deal with third party payers (i.e. car insurance companies). **If you wish to be seen you will be unable to use your insurance and will be responsible for cash price of visit.**

______CHECK-IN: **please arrive 15 minutes before your scheduled time** to ensure all paperwork is completed prior to seeing the physician. **It is your responsibility** to notify the office of any demographic changes or pharmacy changes that need to be done to your account. **Please be prepared to pay for your current visit as well as any past balances** you may owe. This includes co-pays, deductibles, percentages, or fees for non-covered services. For your convenience we take cash, check, or credit cards.

______DISHONORED CHECKS: a $30.00 service fee will be assessed on all dishonored checks. The full amount of the check plus the service fee must be paid by cash or credit card. If payment is not received within 10-15 business days your information will be filed with Montgomery County Hot Check Division. We will be unable to see you until payment is made in full. After 2 occurrences we will no longer be able to accept checks.

______LATE ARRIVALS: **We do our best to keep to our schedule.** When you arrive late it is impossible to stay on schedule and can disrupt other scheduled appointments. **If you arrive 15 minutes late or more you may be asked to reschedule** so that other patients scheduled appointments are not interrupted. **This will also be marked as a "no show" on your account.**

______NO SHOWS: **it is your responsibility to know your appointment time.** If you are unable to make it to your scheduled appointment it is your responsibility to inform us at least 24 hours prior to the scheduled time. **There is a $25 "no show fee"** that will be applied to your account and due prior to being seen again. **Once you have had 3 no shows in a one year's time frame you will be dismissed from the practice** and will be responsible for finding a new primary care physician.

______MEDICATIONS: You will be given enough medication at your office visit to last you until you are due back for a follow up/medication review. **Please keep up with when you are due back for your follow up** to decrease the chances of lapsing in treatment. **It is your responsibility to request refills from your pharmacy.** We recommend contacting them 5 days prior to running out of your medications. **All controlled substances require an office visit. THEY WILL NOT** be prescribed or refilled over the phone.

I have read, understand, and agree to the above office and financial policies. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release of information necessary for insurance filing and pre-certification by signing this statement.

Patients Name: ________________________________ DOB: ___________

Signature: ___________________________________ Date: __________

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Medical Records Release Authorization Form

Patient Name: ______________________________ DOB:____________________

Release my protected health information to the following person(s)/entity:

RECORDS ON DISCS/CD's NOT ACCEPTED

From:_________________________	To: Louetta Family Medicine
Phone:_________________________	Phone: 832-698-4291
Fax:_________________________	Fax: 832-698-4297

The health information you may release subject to this authorization is as follows:

_______ All medical records _______ Lab _______ Radiology _______ Consult Notes

From service date: ____________ to ____________.

Your initials are required to release the following information:

- HIV/AIDS test results/treatment _________
- Drug, Alcohol, Substance Abuse Records _______
- Genetic information (including genetic test results) ________
- Mental Health Records (excluding counseling notes) _________

The purpose for this release of information is for patient care and treatment. This authorization shall be in force and effective for 30 DAYS from the date below. By signing this form, I authorize you to use and disclose the protected health information. I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to Louetta Family Medicine at the address above. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer by protected by Federal HIPPA privacy regulations.

____ ________________________

Signature of Patient or Personal Representative Witness

____

Date