T. Garrett Family Health and Wellness Clinic
Patient Registration Form

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Sex: M◯/F◯ Married◯/Single◯/Divorced◯/Widow◯
SSN# _____
Address: _____
(Street) (City/State/Zip)
Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____

E-Mail Address: _____ Preferred Pharmacy _____
Employer_____ Pharmacy Number _____
Would you be interested in having communications sent to you via your e-mail address? Yes ◯/ No ◯

Primary Care Physician: _____ Phone: _____
(Name)
How did you hear about our practice?_____

Emergency Contact Information:

Name: _____

Address: _____

Home Phone: (____) _____-_____ Work Phone: (____) _____-_____

Relationship: _____

Primary Insurance

Name of Insurance: _____ Member Id/ Group ID _____
Policy holder name: _____ Policy holder D.O.B_____
Policy holder's Social Security:_____ Patient relationship to policy holder_____
Secondary Insurance
Name of insurance: _____ Member ID/Group ID _____
Policy name: _____ Policy holder D. O. B _____
Policy holder's Social Security _____ Patient relationship to policy holder_____

I verify that all above information is accurate. I acknowledge that I am financially responsible for payment. Additionally, there is a $25 no show/ late cancellation fee for appointments cancelled less than 24 hours.

Signature: _____ Date: _____

315 S. Cockrell Hill Rd. Suite 200 Duncanville, TX 75116 Office:972-572-2121
Fax: 214-580-5180 www.tgarrettclinic.com info@tgarrettclinic.com

MEDICAL HISTORY

Name: _____Date of Birth:_____

Please select if you had or currently have any of the following conditions:

☐ Migraine ☐ Diabetes ☐ High Blood Pressure ☐ Thyroid disorder ☐ Food Allergies

☐ Heart Problem ☐ Kidney Disease ☐ Seizure Disorder ☐ Anemia ☐ Indigestion

☐ Constipation ☐ Eating Disorder ☐ Depression ☐ Asthma ☐ Cancer

☐ Sleep Disorder ☐ Chest pain ☐ Hepatitis ☐ Liver problem ☐ Gout ☐ HIV

☐ Osteoporosis ☐ Stroke ☐ Heart Attack ☐ Hearing/Vision problems ☐ Blood Clots

☐ Eczema ☐ Psoriasis ☐ Arthritis ☐ GERD ☐ COPD

Do you have any other medical conditions not listed above?

_____

_____

_____

FAMILY HISTORY: (CHECK ALL THAT APPLY) ☐ HEART DISEASE ☐ STROKE ☐ ARTHRITIS ☐ OSTEOPOROSIS ☐ ALZHEIMER'S ☐ GOUT ☐ CANCER(TYPE)_____OTHER:_____

_____

Are you on any special or limited diets? ☐ Gluten-free ☐ Lactose-free ☐ Vegan/Vegetarian ☐ Other

REVIEW OF SYSTEMS: Please circle any SIGNIFICANT SYMPTOMS you are currently experiencing:

- NONE
- CONSTITUTIONAL: weight gain – weight loss – fatigue – loss of appetite – fevers – chills – other_____
- EYES: blurred vision – eye pain – discharge from eye – other _____
- HEAD & NECK: severe headaches – sore throat – nasal discharge – nose bleeds – decreased hearing – lightheadedness – other _____
- BREAST: lumps – tenderness – nipple discharge – other_____
- CARDIOVASCULAR: chest pain – irregular heart beat – fainting spells – other _____
- RESPIRATORY: shortness of breath – cough – wheezing – other_____

• GASTROINTESTINAL: nausea – vomiting – diarrhea – constipation – heartburn – abdominal pain – blood in stools – incontinence of stools – hemorrhoids – other_____

• GENITOURINARY: urinary frequency – pain with urination – blood in urine – urinary incontinence – difficulty urinating – vaginal discharge – pain with intercourse – bleeding with intercourse – significant PMS – other _____

• SKIN: rash – itching – acne – abnormal hair growth – other_____

• NEURO: headaches – weakness – numbness – other _____

• MUSCULOSKELETAL: joint pain – joint swelling – muscle weakness – muscle pain – other _____

• ENDOCRINE: increased thirst – increased urination – hair loss – heat intolerance – cold intolerance – other_____

• PSYCHIATRIC: anxiety – depression – confusion – other_____

• HEMATOLOGIC: easy bruising – easy bleeding – lymph node enlargement – other _____

• ALLERGIC: sinus allergies – skin allergies – other_____ I have filled out this form completely and to the best of my ability.

Reason for today's visit?

_____

List any medications, vitamins or natural supplements you are currently taking

Prescription Medications	Vitamins and/or Supplements

List all of your Medication and Food Allergies. Also list what type of reaction you have:

Medication or Food Allergies	Allergic Reaction

Have you had any hospitalizations or Surgeries in past 10 years? If Yes, list below with the year:

1. _____ Year _____
2. _____ Year _____
3. _____ Year _____
4. _____ Year _____

If there is a need, do you give us permission to contact your primary care physician?

☐ Yes ☐ No

When was your last physical? (Month/Year) _____

Smoking history: ☐ yes ☐ No
If yes how many years? _____ How many Packs a day _____
Drug Abuse: ☐ yes ☐ NO
Alcohol Abuse ☐ yes ☐ NO If yes how much a week?_____
Social Drinker ☐ yes ☐ NO If yes how much a week? _____

WOMEN ONLY:
When was the beginning of last menstrual cycle? _____
Are menstrual cycles normal? _____
Most recent pap smear: _____
Are you taking birth control? _____ if yes which kind _____
Is there a possibility you could be pregnant? _____
When was your last mammogram? _____

I certify that the above information I have provided on this form is correct. All Statements on this patient intake form are accurate and true to the best of my knowledge. I understand that treatments will be based on the information provided herein. If I willingly withhold knowledge from the nurse practitioner, I accept full liability from any consequences that may arise.

By signing, I understand and will follow the policy stated in this contract.

_____ _____
Signature of Patient, Parent or Guardian **Date**

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Advanced Practice Nurse Consent for Medical Treatment

T. Garrett Family Practice and Wellness Clinic is owned and operated by Travicia Garrett, Board Certified Family Nurse Practitioner. Family Nurse Practitioner is the primary provider of the clinic, Travicia Garrett has a master's Degree in nursing. Off-Site Supervising physician is Dr. Teriya Richmond, MD. The Advance Practice Nurse has had the required training and skill set to take care of all age groups. Family Nurse Practitioners have passed the requirements by the state, to diagnose, monitor, educate, treat and provide prescriptions to all age groups.

I _____am aware that I will be receiving care from an Advanced Practice Nurse / Family Nurse Practitioner

Patient Signature _____ Date_____

Patients Name_____ D.O.B _____

Parent/Guardian Signature and Date

_____

PRESCRIPTION MEDICATION POLICY

T. Garrett Family Health and Wellness Clinic is committed to providing quality health care services for our valued patients. In keeping with this commitment, we discourage any potential issues of fraudulent use or abuse of controlled medications. It is our policy here at T. Garrett Family Health and Wellness Clinic, that **patients are to abide by the specific instructions given for each medication prescribed. If there is evidence that there is misuse of any of the prescribed medications, we reserve the right to discontinue refills of the medicine and issue immediate discharge from our practice.** T. Garrett Family Health and Wellness Clinic reserves the right to refer patients to other medical specialists if patient's needs are beyond the scope of practice of our medical facility.

I _____ certify that the above information I have provided on this form is correct. All statements on this patient intake form are accurate and true to the best of my knowledge. I understand that treatments will be based on the information provided herein. If I willingly withhold knowledge from the nurse practitioner, I accept full liability from any consequences arising there from.

By signing, I understand and will follow the policy stated in this contract.

_____ _____

Signature of Patient, Parent or Guardian **Date**

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Authorization to Bill Insurance

Client:_____Guardian (if Minor)_____

Phone:_____Email:_____

Address: _____

Insurance Company:_____ Policy No._____

I, the undersigned, hereby certify and attest that I have sought evaluation, treatment, or medical advice from the staff at the clinic named above. I therefore authorize the medical staff and personnel to release my or my minor child's medical information to the insurance company listed above for the purpose of determining and receiving benefits for medical bills.

I understand and acknowledge that the medical staff will submit my claim to the insurance company on my behalf. I further understand that I will be held responsible for any amount of my medical bills not covered by my insurance policy or claims, and that I will be responsible for paying all deductibles, fees, co-payments, and co-insurance payments required.

I understand that any portion of my medical bills not covered by insurance will be billed to me at the address I have provided above. Non-compliance or defaulting on payments may result in denial of service and/or a legal claim against me for non-payment.

Signature_____ Date_____-

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Protected Health Information (PHI) / HIPAA

Patient Keep Copy

Patient Name (Print) _____ Date_____

HIPAA

T. Garrett Family Health and Wellness Clinic upholds the standard of the HIPAA laws. As a patient, we want you to know:

- We respect the privacy of your personal medical records and will do all we can to secure and protect that privacy.
- When it is appropriate and necessary, we provide the minimum information to only those in need of your health care information, treatment, payment or health care operations, in order to provide health care that is in your best interest.
- You may refuse to consent to the use or disclosure of your personal health information, but *this must be in writing*.
- Under this law, we have the right to refuse to treat you should you refuse to disclose your Personal Health Information (PHI). This information is critical in making appropriate medical decisions.

If you have any questions regarding this consent, please speak with one of the staff of *T. Garrett Family Health and Wellness Clinic.*

TREATMENT CONSENT AND AUTHORIZATION

I consent to medical screening and medical examination to determine my current health status, other medical evaluations, diagnostic procedures, routine care, and medical treatments which the medical and professional staff of *T. Garrett Family Health and Wellness Clinic* may deem necessary, advisable, or appropriate. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of the procedures and/or treatments.

I have read the above information and consent that it is correct to the best of my knowledge. My signature here indicates compliance with the above policies.

_____ _____

Signature of Patient/Guardian Date

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T. Garrett Family Health and Wellness Clinic is required to:

Maintain the privacy of your health information.

- Provide you with this notice as to our legal duties and privacy practices with respect to your information we collect and maintain about you.
- Abide by the terms of this practice.
- Notify you if we are unable to agree to a requested restriction, and accommodate any reasonable request you may have to communicate health alternative means or alternative locations.
- We will not use or disclose your health information without your authorization, except as described in this notice.

_____ (initial)

WE ARE PERMITTED TO USE, AND MAY BE REQUIRED, TO DISCLOSE YOUR PHI UNDER SPECIAL CIRCUMSTANCES:

1. **Disclose Required By La**w: Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law, including health oversight activities, court or administrative orders or similar legal proceedings.
2. **Public Health Risk:** Our practice may disclose your PHI to public health authorities who are authorized to collect information for such purposes as maintaining vital records, preventing or controlling disease, injury, or disability; or notifying a person regarding potential exposure to a communicable disease.
3. **Serious Threats to Health of Safety**: Our practice may disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.
4. **Deceased Patients:** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
5. **Organ Donor:** Our practice may release PHI to a medical facility for tissue procurement of transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
6. **Worker's Compensation:** Our practice may release your PHI for workers' compensation and similar programs.

_____ (initial)

Our practice may contact you or your authorized representatives (see authorization form attached) to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The practice will routinely contact patients via telephone at home and /or work, via mail at home, and unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appointments and billing questions.

All requests for medical records should be written and contain:

- **Social Security Number**
- **Date of Birth**
- **Insurance Carrier**
- **Mailing Address**
- **Written Signature**

In addition an advanced fee will be accessed for copy and mailing of all medical records information.

At no time will any person, including your spouse, be able to obtain information from your medical record without prior written authorization. Only parents or legal guardian of a child under the age of 18 will be allowed to access medical record information, with proof of child's social security number and date of birth.

Patient Rights

ACKNOWLEDGEMENT

I acknowledge that I have received the Notice of Privacy Practices from T. Garrett Family Health and Wellness Clinic

Indicated below are names of any Person(s) to who I would like T. Garrett Family Health and Wellness Clinic to allow disclosure of Individually Identifiable Health Information (IIHI). (Please, specify the type of information that may be disclosed, such as lab test, appointment information, prescription information, etc. You may indicate "All" if appropriate).

Name	Relation (Spouse, Child, Friend, etc.	Allowed Disclosure
1.		
2.		
3.		

_____ _____

Patient Signature Date

_____ _____

Signature Legal Guardian Date

Relationship to Patient_____

FOR OFFICE USE ONLY
Date Received: _____
Received By: _____

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