ESTABLISHED PATIENT REGISTRATION AND HEALTH UPDATE

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

STREET ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE: _____ OFFICE: _____ CELL: _____

E-MAIL ADDRESS: _____

EMPLOYER: _____ **OCCUPATION**: _____

SOCIAL SECURITY #: _____

MARITAL STATUS : (Circle) Single Married Separated Divorced Widow

SPOUSE'S/PARTNER's NAME: _____ **DATE OF BIRTH**: _____

HOME PHONE: _____ **OFFICE**: _____ **CELL:** _____

SOCIAL SECURITY#: _____ **EMPLOYER**: _____

IF UNDER 18, PARENT GUARDIAN _____

INSURANCE INFORMATION UPDATE

We will ask to scan your insurance cards, driver's license and prescription card into our system.

BILLING NAME *(If other than patient)*: _____ RELATIONSHIP_____

BILLING ADDRESS: *(if different than mailing*) _____

Primary Insurance Name: _____

Secondary Insurance Name: _____

I attest that the insurance information noted above is the only coverage I have at the current time. Unless noted above, I have no secondary coverage.

Signature_____ Date_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Dr. Stanley Stein for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Stanley Stein to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits,

MEDICARE/MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all medical records upon request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

PATIENT (Please Print) _____ Date: _____
PARENT/GUARDIAN _____
SIGNATURE _____

PAYMENT IS REQUIRED AT THE TIME OF SERVICE

MEDICAL HISTORY UPDATE FORM

Please provide us with pertinent medical information since your last visit

Personal Medical History – Have you been diagnosed with any new medical conditions?

Diagnosis	Date Diagnosed

Surgical History – Have you had any surgeries since your last visit?

Name of Operation	Date

Family Medical History – Have any members of your family been diagnosed with Cancer, Colon Cancer, Colon Polyps , Gallbladder Disease, Heart Disease …..

Family Member	Relationship	Diagnosis	Date

Are you currently taking blood thinning medication?

Name of Medication	When was it started	Prescribing Physician/phone

What Medications are you currently taking?

Name of Medication	Dose/Frequency

Allergies to Medication? Please list _____

Do you have any specific concerns you would like Dr Stein to address during your visit?

_____

Preferred Pharmacy or prescription program: _____
Location:_____ **Phone:** _____

MEDICATION HISTORY CONSENT FORM

Date _____

Patient Name: _____ **Date of Birth:** _____

Dr Stein requests permission to access your current and past medication history. By giving your consent, Dr Stein will be able to query and view electronically all your current medications and those you have taken in the past.

Please indicate your response below:

_____ Yes, I give my consent.

_____ No, I do not consent.

RECORD EXTRACTION PERMISSION

Dr Stein requests permission to allow extraction of medical records when requested by insurance companies, physicians or medical treatment facilities to promote interoperability and continuity of care. By giving your consent, your medical records can be accessed, and a record will be kept in your electronic chart with details of each record extraction.

Please indicate your response below:

_____ Yes, I give my consent.

_____ No, I do not consent.

This consent is effective _____ (enter today's date) and is in effect until further notice.

_____Signature _____Printed Name

fbg FORT BEND gastroenterology
Stanley H. Stein, M.D., P.A.

Personal Health Information Communication Plan

I. Please list the family members or other persons, if, any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and healthcare operations):

Name_____ Relationship_____ Phone Number _____

Name_____ Relationship_____ Phone Number _____

II. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY.

Name_____ Relationship_____ Phone Number _____

Name_____ Relationship_____ Phone Number _____

III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

_____

IV. Please print the alternative daytime telephone number(s) where you would like to receive communications regarding your appointments, lab and x-ray results, and other healthcare information:

( ) _____ ( ) _____

I am fully aware that a cellular phone is not a secure and private line.

V. Can confidential messages (i.e., Appointment reminders) be left on your telephone answering machine or voicemail? _____ Yes _____No

PATIENT NAME _____ (Guardian if under 18 years))

_____ _____

PATIENT or GUARDIAN SIGNATURE (circle one) DATE