Houston Primary Care
REGISTRATION FORM

(Please Print)

Today's date:	Email:

PATIENT INFORMATION

Patient's First and last name:	Middle	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Race:

City:	State:	Zip Code:	Home Phone no: ( )	Cell Phone no: ( )

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	☐ Dr.	☐ Insurance Plan	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Name of primary insurance				
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Houston Primary Care or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

Houston Primary Care, Inc.
1719 Russell Parkway, Bldg 700
Warner Robins, GA 31088

PATIENT FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to building a successful physician-patient relationship with you. Please understand that payment for services are a part of that relationship. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

PATIENT INFORMATION:

A fully completed, current patient registration will be on file in the patients chart. Patient registration will be updated yearly and will include where the patient can be reached by phone. A signature by the responsible party is required. If there is a change of residence or phone numbers it is the responsibility of the patient to notify us of the change.

INSURANCE CLAIMS:

PRIMARY INSURANCE: Houston Primary Care will file claims with the patients' insurance upon the patients submission of proof of coverage (i.e. insurance care, identification number and group number) Patient is also required to bring their insurance care to every visit. Upon receipt of the insurance card Houston Primary Care will submit the health insurance claim form.

SECONDARY INSURANCE: Claims will be filed with secondary insurance if adequate information is received at the time of service. However, if payment is not received in our office within 45 days after filing the balance will be transferred to the patient and due upon receipt.

While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility for all services rendered.

PATIENT FINANCIAL RESPONSIBILITY:

If insurance is not to be filed by **Houston Primary Care, Inc** is not a participating provider, full payment is due at the time of services rendered.

CO-PAYMENTS AND NON COVERED SERVICES ARE DUE AT TIME OF SERVICE.

Deductibles and Co-Insurance will be collected after we receive payment from your insurance company.

We Accept checks, money orders, cash and credit cards excluding AMEX. There will be a $25.00 charge for all returned checks.

Houston Primary Care

PATIENT IS RESPONSIBLE FOR ALL FEES, COVERAGE IS NOT A GUARANTEE OF PAYMENT. IF CLAIM SUBMITTED BY OUR OFFICE IS DENIED, BALANCE WILL BE TRANSFERRED TO PATIENT. PATIENT WILL BE RESPONSIBEL FOR OBTAINING REIMBURSMENT FROM INSURANCE COMPANY UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

ASSIGNMENT & RELEASE I hereby authorize my physician to furnish my insurance company (ies) or their representatives information concerning my illness or treatments. I hereby assign the payment of my insurance benefits to my physician for medical services rendered and understand that I am responsible for any amounts not covered by insurance.

ACCOUNTS PAST DUE:
Visa/MasterCard/Discover payments are accepted by phone.
In the event an account is turned over to collection, the person financially responsible for the account will be responsible for all collection costs. A patient may remit in full all outstanding charges after the account has been placed with collections but the collection charge will also be due even if presented at office. Houston Primary Care is charged collection fees once the account has been processed through collections and is still responsible to repay fees collected in office.

MEDICAL RECORDS:
If you require a copy of your records there is a charge for this. The charge varies depending on how many pages are needed to be copied. There is no charge for records to be sent to another facility but please notify us as soon as possible. Legally we have 30 days after we receive written authorization from the patient.

NO SHOW/CANCELLATION CHARGE:
In order to be respectful of the medical needs of the community, please be courteous and call our office promptly if you are unable to attend an appointment. We require at least 24 hours notice, so that your appointment time can be reallocated to someone else. ***Late cancellations will be considered as a "no show".***
A "***no show***" is someone who misses an appointment without canceling it at least 24 hours in advance or who fails to keep a scheduled appointment. In the event a 24 hour notice is not given, a fee of $25.00 will be charged for missed office visits at the discretion of your physician.

I have reviewed and understand **Houston Primary Care** Financial Policy.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY _____ DATE _____

PATIENT NAME _____ DATE OF BIRTH _____

WITNESS _____ DATE _____

Houston Primary Care
Medical History

Allergies to Medications, X-ray Dyes, or Other Substances ☐ No ☐ Yes
(If yes, please list names of medicine and type of reaction):

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Past Medical History and Review of Systems
(Please circle if you have had problems with or are presently complaining of any of the following):

1. High Blood Pressure
2. Diabetes
3. Cancer
4. Heart disease
5. Chest pain/Chest tightness
6. Shortness of breath
7. Swollen Ankles
8. Palpitations
9. Lightheadedness
10. Frequent Urination
11. Rheumatic Fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent Cough
16. T.B.
17. Hay fever
18. Abdominal discomfort
19. Indigestion
20. Nausea
21. Vomiting
22. Constipation
23. Diarrhea
24. Blood in stool
25. Change in bowel habits
26. Unexplained weight gain/loss
27. Hemorrhoids
28. Gall bladder disease
29. Colitis
30. Hepatitis or jaundice
31. Thyroid Disease
32. Head or Neck radiation
33. Headache
34. Kidney disease
35. Kidney Stones
36. Difficulty urinating
37. Arthritis
38. Low back problems
39. Skin diseases
40. Blood disorders
41. Venereal disease
42. Anxiety
43. Depression
44. Anemia
45. Alcohol Abuse
46. Drug Abuse
47. Gout
49. _____

_____
_____
_____
_____
_____
_____

Gynecologic and Obstetric History

Age at onset of periods: _____ Frequency: _____ Pregnancies: _____
Abortions: _____ Births: _____ Miscarriage: _____

Prolonged or abnormal bleeding: ☐ No ☐ Yes (Please Describe): _____
Leakage of urine: ☐ No ☐ Yes (Please Describe): _____
Pelvic Pain: ☐ No ☐ Yes (Please Describe): _____
Abnormal discharge: ☐ No ☐ Yes (Please Describe): _____
History of abnormal Pap smear ☐ No ☐ Yes (Please Describe): _____

Medications (Prescriptions, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Date	Drug Name	Date

Pharmacy Name	Phone Number	Location