7692 Eldorado Parkway
McKinney, Texas 75070
972.562.8388 (Phone)
972.540.2219 (Fax)

Health History Form

Full Name: ______________________________________M __ F __ DOB: ________________
Medical Allergies: ____
____

Disease (Check all that apply)	Self	Mom	Dad	Sis	Bro	MGM	MGF	PGM	PGF
Allergic Rhinitis/Hay Fever									
Anemia									
Arthritis									
Asthma									
Blood Clotting									
Blood Transfusion									
Breast Cancer									
Cataracts									
Colon Cancer									
Depression									
Anxiety									
Mental Illness									
Diabetes									
Drug/Alcohol/Physical Abuse (Circle which apply)									
Emphysema									
Lung Problems									
Endometriosis									
Hearing Problems									
Heart Disease									
Heart Attack									
High Blood Pressure									
High Cholesterol									
Irritable Bowel Syndrome									
Kidney Problems									
Migraines									
Neurological Disease									
Peptic Ulcer Disease/ GI Problems									
Positive TB Test/Tuberculosis									
Sexually Transmitted Disease									
Stroke									
Thyroid Problems									
Other:									

Hospitalizations	
Reason:	Yr:
Reason:	Yr:
Reason:	Yr:
Reason:	Yr:
Reason:	Yr:
Reason:	Yr:
Reason:	Yr:
Reason:	Yr:

Surgeries	
	Yr:
	Yr:
	Yr:
	Yr:
	Yr:
	Yr:
	Yr:

Do you use any form of Tobacco?	
Yes	No
Type & Amount:	
Do you drink Alcoholic Beverages?	
Yes	No
Amount:	
Treated for Substance Abuse?	
Yes	No
When?	
Sexually Active?	
Yes	No

Women Only:

Age Menses Began:
Regular Menses Y__ N__ LMP_____
Last PAP _____ Last Mamm _____
Ob/Gyn Dr.__________________
Number of Pregnancies: _______
Form of Contraception:_________

Current Medications	Dosage	Frequency
1.		
2.		
3.		
4.		

I certify that the above information is correct and true to the best of my knowledge. I will not hold my doctor or any members of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: ____ Date: _________________________

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Patient Information
(Please Print)

Full Name: ____

Address: ____

City: ____ State: _____ Zip: ________________

Primary number: _______________________________ Email address:______________________

Birth date: ____________________ Age: ______ SSN: _____________________ Sex: M __ F __

Drivers License: _____________ Single: __ Married: __ Widowed: __ Separated: __ Divorced: __

Patient Employed by: ____

Business Address: ____

In case of emergency who should be notified? (Someone not living with you)

Name: _____________________________________ Phone Number: ________________________

Primary Insurance

Full Name of Responsible Person: ____

Relation to Patient: ___________________ Birth Date: ______________ SSN: __________________

Address (If different from patients):____

City: ______________________ State: _____ Zip: ______________ Phone: _____________________

Person Responsible Employed by: ____

Business Address: _______________________________________ Phone: _____________________

Additional Insurance

Is patient covered by additional Insurance? Yes ___ No ___ Subscriber Name: ____________________

Relation to Patient: ____________________ Birth Date: _________________

Address (If different from patients): ____

City: ______________________ State: _____ Zip: ______________ Phone: _____________________

Subscriber Employed by: ____________________________ Business Phone: ____________________

Insurance Company: _________________________________ SSN: ___________________________

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Patient Consent for Release of Personal Health Information (PHI)

Many of our patients allow family members such as their spouse, parents, or others to call & request test results/procedures, appointments & billing information or for prescription/sample pick up. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's written consent. If you wish to have your protected health information (PHI) released to anyone other than yourself, you must complete this form. This form will expire by written notification from you ONLY.

I, ______________________________________, give my consent to McKinney Family Medicine to release protected health information (PHI) such as; ***lab results, medication changes, prescriptions, samples, appointments, billing information, etc.*** to the following individuals *in person or via telephone:*

Name	Relationship	Phone # (if different from patient)

AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION BY ALTERNATE MEANS

Please check all that apply:

O May leave detailed message on voicemail at home #: __________________________________

O May leave detailed message on voicemail at work #: __________________________________

O May leave information with spouse (name): ____

O May leave information with other family member (name): ______________________________

O May leave detailed message on mobile phone #: ______________________________________

O Do NOT leave any detailed message on any phone.

O May send email to: ______________________________________

**Please note: Detailed message includes lab/test results, medication, and/or billing information.

Signature ___________________________________ Date of Birth_________________________________

Relationship: Self Spouse Parent/Guardian to ___________________ Other ____________
(Patient Name & DOB)

Date ___________________________________

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Assignment and Release

With Insurance

I, _______________________________________ the undersigned certify that I (or my dependent) have insurance coverage with _____________________ (Insurance Company) and hereby assign/transfer and set over to McKinney Family Medicine all my rights, title and interest to my medical reimbursement benefits under my insurance policy. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that full payment (including co-payment) is expected at time of service. I hereby authorize McKinney Family Medicine to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party ____

Relationship __________________________________ Date _______________________________

Without Insurance

I, _______________________________________ the undersigned certify that I (or my dependent) do not have insurance coverage with any company. I understand that I am responsible for all charges. I understand that full payment is expected at time of service. I understand my responsibility and acknowledge it by signature on this form.

Signature of Responsible Party ____

Relationship __________________________________ Date _______________________________

Acknowledgement of Receipt

I, ____ have received a copy of McKinney Family Medicine's Office Policy and Notice of Privacy Practices.

Signature of Responsible Party ____

Relationship __________________________________ Date _______________________________

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Medical Records Release Authorization

Patient's Full Name: ___________________________________ DOB: _________________________________
Phone #: ____ SS#: _________________________________
Address: ____

I authorize records: (please select one):
( ) To be released **TO** McKinney Family Medicine from ____

Address: ____

Phone: ____________________________ Fax: __________________________

( ) To be released **FROM** McKinney Family Medicine to ____

Address: ____

Phone: ____________________________ Fax: __________________________

To release the following:
_____ any and all medical records
_____ operative report
_____ recent PAP results
_____ recent lab results
_____ office visit for ___________ (date)
_____ other ____________________

The purpose of this disclosure is for ***treatment/payment/healthcare operations*** unless specified here:
____

This authorization gives McKinney Family Medicine permission to request your medical records from any health care provider that you have received treatment from as specified above for the duration that you have direct treatment relationship with McKinney Family Medicine. McKinney Family Medicine is authorized to furnish information even though the confidentiality of the information may be protected by Federal or State laws and regulations. **This includes any and alcohol and/or drug treatment records or psychiatric records and any information related to HIV or sexually transmitted disease testing or results that are in the record, unless specified above.** McKinney Family Medicine is released and discharged from any liability, and the undersigned will hold McKinney Family McKinney Family Medicine harmless for complying with this information.

I understand the following:
- ✓ I am not required to sign this authorization.
- ✓ I may revoke this authorization at any time by presenting my written revocation to McKinney Family Medicine, 7692 Eldorado Pkwy., McKinney, TX 75070.
- ✓ The revocation will not apply to information that has already been used or released under this authorization.
- ✓ Physician's office has the right under Texas State Law to require payment up front for reasonable costs of copying and mailing before furnishing the medical records.

____ ____
Signature of Patient or Legal Representative Printed Name of Patient or Legal Representative

____ ____
Relationship to patient or Legal Representative Date

____ ____
Witness Date

NOTICE TO PERSON OR AGENCY RECEIVING THIS INFORMATION: *This information has been disclosed to you from records whose confidentiality is protected. Laws and Regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient.*