PATIENT INFORMATION: **TODAY'S DATE**____________

Last Name: ____ First Name: _______________________________________ Middle Initial:___________

Date of Birth: ________________ Sex: ____Male ____Female SS#:___________________________ Marital Status:__________________________

Street Address: _____________________________________ City: _______________________ State: _____________ Zip Code: _______________

Home Phone: ___________________________ Work Phone: ___________________________ Mobile Phone: _______________________________

Email: _________________________________ Contact Preference: (Home Phone) (Work Phone) (Mobile Phone) (Mail) (Patient Portal)

AUTHORIZATION: I authorize you to leave automated reminder calls on my mobile device ____YES ____NO

Referring Provider: __________________________________ Patient PCP: __________________________________

Race: (Arab) (Asian) (Black or African American) (Other Race) (White) (Other) Preferred Language: English Other _____________________

Ethnicity: (Central American) (Cuban) (Dominican) (Hispanic or Latino/Spanish) (Latin American/Latin, Latino) (Mexican) (Not Hispanic or Latino) (Puerto Rican) (South American) (Spaniard)

How did you hear about us? (Physician) (Internet Search) (Newspaper) (Television) (Hospital Partner) (BHS Screening Bus) (Baptist Community Event) (Website) (Insurance Company) (Baptist Emergency Hospital) (Friend/Family) (Employer) (Other _________________________)

GUARDIAN INFORMATION:

Guardian Last Name: __________________________________ Guardian First Name: ___________________________ M. Name:______________

EMERGENCY CONTACT INFORMATION:

Last Name:_________________________ First Name:________________________ Phone:________________ Relationship:_____________________

INSURANCE INFORMATION: *Please bring insurance card(s) to the visit*

Insurance Plan Name: __________________________________ Policy Holder Name: ______________________ Policy Holder DOB: _______________

EMPLOYER INFORMATION:

Employer Name: ____________________________________ Employer Phone: ______________________________ Occupation:______________

CLINICAL INFORMATION:

Preferred Pharmacy: ____Phone: _____________________ Fax: ____________________

Preferred Laboratory: ____

Protected Health Information Authorization:

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

Name	**Relationship to Patient**	**Type of information** All	Schedule	Medical	Billing
________________________	________________________________	**Y/N**	**Y/N**	**Y/N**	**Y/N**
________________________	________________________________	**Y/N**	**Y/N**	**Y/N**	**Y/N**
________________________	________________________________	**Y/N**	**Y/N**	**Y/N**	**Y/N**
________________________	________________________________	**Y/N**	**Y/N**	**Y/N**	**Y/N**

Specific Instructions or Limitations:____

We will continue to rely on the information given here when communicating with family members or others involved in you care unless you request changes. Please promptly notify our office if you wish to alter the designations above.

Signature of Patient:____**Date:**___________________________

To revoke this authorization, please send a written request to our office.

POLICY ACKNOWLEDGEMENTS AND RELEASES

Please read each of the following statements carefully and sign as your authorization, understanding, and agreement to each statement.

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to the physician. I also authorize the physician to release any information required to process this claim to my employer and/or any third party vendor.

Signed: ____ Date: ________________________

MEDICARE BENEFICIARY ASSIGNMENT AND RELEASE: I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by ____________________. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Signed: ____ Date: ________________________

FINANCIAL OBLIGATION: I hereby acknowledge that I understand there may be services provided that will not be covered by my insurance carrier, and fully understand that I am fully responsible for any and all charges not covered by my insurance carrier. I understand that payment may be requested at the time of service or I may be billed for such services subsequently.

Signed: ____ Date: ________________________

CONSENT FOR TREATMENT: I hereby authorize the physician, nurses, medical assistants and staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

Signed: ____ Date: ________________________

ADVANCED DIRECTIVE: Do you have an advance directive (living will/power of attorney)?

_____Yes _____No If yes, please provide a copy for our records.

MEDICATION HISTORY AUTHORITY: I authorize BHS Physicians Network and BHS Physicians Specialty to obtain Medication History Authority.

Signed: ____ Date: ________________________

NO SHOW POLICY

Patients who fail to present for a scheduled appointment will be considered a "no show". Patients who fail to cancel the appointment 24 hours prior to the appointment will also be considered a "no show".

A patient determined to be a "no-show" will be charged $25.00 for each episode.

Patients who have missed 3 appointments in a 12 month period will be considered a "chronic no show". A patient determined to be a "chronic no show" may be discharged from the practice.

_______________________________ has read and understand the above stated policy.
Patient Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: You may refuse to sign this acknowledgement.

I, ____, DOB, ____________________,

have received a copy of this office's Notice of Privacy Practices.

____
Print Name

____
Signature

____
Date

For Office Use Only:

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

__________Individual refused to _______accept Notice ________ sign Acknowledgment

__________Communications barriers prohibited obtaining the acknowledgment

__________An emergency situation prevented us from obtaining acknowledgment

Other (Please specify)____

We appreciate the opportunity to serve you. The following information and expectations are set forth in an effort to provide all our patients with the highest quality care:

____ MEDICATION REFILL REQUESTS: We request that you first contact your pharmacy for refills. We will not do same day refills. The pharmacy will work with us to process your requests. Refills should be requested at least 72 hours (3 business days) prior to your refill date. The practice is closed on weekends and refill requests will not be accepted. Please contact our office to confirm that we have received the refill request. If you have not been seen by our provider in the past year, we will not refill your medication without an appointment.

____ PAYMENTS: All applicable fees, deductibles, coinsurance, co-pays or outstanding balances must be paid at the time of your appointment. We accept cash, checks, Visa, MasterCard, Discover and American Express. There is a $25 charge for all returned checks.

____ CHANGES OF INFORMATION: Please provide us with any changes regarding your address, phone number or insurance information as soon as possible. Failure to notify us of any updates may result in you being financially responsible for the services rendered.

____ FMLA & OTHER FORMS: Should you require our office to complete FMLA or other applicable forms, there is a fee starting at $35. Fees are due when forms are completed. Please allow 7 business days for us to complete forms. Please inquire with the staff regarding forms that need to be completed and applicable fees.

____ APPOINTMENT TIME: We ask that you arrive on time for your appointments. Arrivals later than 15 minutes will require appointment rescheduling.

____ CELL PHONES: We ask you to please have your cell phone off during your office visit.

____ CANCELLATION/NO SHOWS: If you need to cancel your appointment, we ask that you give us 24 hours notice. If you fail to notify us and miss your appointment, there will be a $25 fee and possible termination from the office if excessive. There will also be a fee of $25 if you cancel your appointment on the same day.

____ Office Visits: At the time of scheduling, please notify the staff of all the reasons for which you are requesting an appointment. In respect to all our patients' time and to maintain the efficiency of the practice, only complaints for which the visit was scheduled will be addressed. We will address all your healthcare needs, but it may require multiple visits.

We ask that you initial each area and sign below. By signing below, you acknowledge having read, understood and are in agreement with the above information and expectations.

______________________________	______________________________	________
Patient Signature	**Printed Name**	**Date**

REQUEST FOR MEDICAL RECORDS

Date: ____________

Name of patient: __________________________

Date of birth: _____________

Social Security # ______________________

I _____________________ **r**equest that all my records be sent to the following physician.

Dr. Susan Rivera
Dr. Tracy Lyon
Dr. Henry Garza
Olivia Green, CNM
Charla Hutchens, NP

8715 Village Drive Ste 305
San Antonio, TX 78217
or Fax: (210)- 433-6329

16977 IH 35 NORTH
SCHERTZ, TX 78154
Fax: (210) 585-4245

If you have any question please call us at (210) 226-7827

Thank you for your prompt attention in this matter.

____ ______________________
Patient signature Date

New Patient Questionnaire

Patient Name: ______________________________________ **Date of Birth:** _________________

All Prior Physician(s):

Name: Address Phone/Fax:

____

____

____

CURRENT MEDICAL PROBLEM

What problem brought you here? ____

What symptoms are you having? ____

When did the symptoms begin? ____

Has your weight changed in the last six months? No Yes If yes, Gained _____lbs Lost ______lbs

Has your overall energy level changed? Increased Decreased stayed the same

PAST MEDICAL / SURGICAL HISTORY

Please list any medical problems (e.g. diabetes, high blood pressure, cancer etc)

Problem:	Problem:

Number if times you've been pregnant? _____ Number of live births? ______

Number of miscarriages? _____ Number of abortions? ______

Age you started your period? _____ Age at menopause? ______

Hormone replacement? No Yes Number of years? ______

Please list any previous operations or procedures

Procedure / Operation	Date	Surgeon	Hospital

Patient Name: ___________________________________ **Date of Birth:** ________________

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Stroke						
Heart Disease						
Diabetes						
Hypertension						
Cancer						
Other						

Pharmacy of Choice:
Name: _____________________ **Address:** _____________________**Phone:** ________________

MEDICATIONS:
Please list all medications or pills that you take, whether or not prescribed by a physician. Record them as they are on the drug box/bottle. Please include all vitamins, herbal supplements, and/or over the counter medications.

Medicine or pill name	Dose (e.g., 50 mg)	How many times per day?	Why do you take this?

Are you allergic to any medications, pills, food, etc.?

Item	Reactions?	Item	Reactions?

Are you allergic to shellfish, eggs? Yes No Don't know
Are you allergic to contrast or dye injected in a medical test? Yes No Don't know
If so, what happened? Rash Short of breath Other ______________________

VACCINATIONS
Have you received a pneumonia vaccine with the past 5 years. No Yes, date _______ Don't know
Have you received a flu vaccine this season? No Yes, date _______ Don't know
When was your last tetanus? Date: _____________ Don't know

PREVENTATIVE CARE
When was your last physical? _________ When was your last mammogram? ___________
When was your last pap smear? _________

Patient Name: ___________________________________ **Date of Birth:** ________________

Do you currently or have you ever used tobacco products? Never No/Quit Yes Would like to quit

If yes or quit, how much per day? _______ Age started? ________ Age quit? ______

Type: Pipe Cigars Smokeless tobacco

Cigarettes, have you smoked this past year? No Yes

Do you or have you used alcohol? Never No/Quit Yes

If yes or quit, how much per day? _______

Type: Beer Wine Liquor Moonshine

Do you or have you used recreational drugs? Never No/Quit Yes, type: ________________

Do you have an advance directive (living will, durable power of attorney)? No Yes (please provide copy)

Do you have any religious or cultural beliefs that you would like your doctor to know about? No/Yes

If yes, please explain;____

____