Patient Registration Form

Last Name: ____________________ **First Name:** ____________________

Address: ____

City: ____________________ **State:** __________ **Zip Code:** __________

Home Phone: __________ **Cell Phone:** __________ **Work Phone:** __________

Email address: ____

Sex: ☐ Male/ ☐ Female **Date of Birth:** __________ **Age:** ______ **Marital Status:** __________

Race/Ethnicity: ____________________ **Primary language:** ____________________

Employer Name: ____________________ **Occupation:** ____________________

Name of Spouse: ____________________ **His/Her Employer Name:** ____________________

Emergency Contact: ____________________ **Relation:** ____________________

Emergency Contact Phone Number: ____________________

Primary Insurance Holder:____________________**Date of Birth:**____________________

PrimaryIns:__________**ID/Subscriber #**____________________**Group #**__________

Secondary Ins:__________**ID/Subscriber #**____________________**Group #**__________

Pharmacy Name: ____________________

Address/Location____________________**Phone:**____________________

Patient Signature:____**Date:**__________

Financial Policy

PAYMENT RESPONSIBILITY

Payment for all services is the responsibility of the patient. As a courtesy to all our patients, Pear Tree Medical Associates will file a claim with your insurance company. However, this is not a guarantee of payment; therefore, it is important for you to be aware of your insurance coverage and limitations. Ultimately, financial responsibility for services rendered rests with the patient or his/her family regardless of the nature or extent of insurance coverage. The patient is further responsible for co-payments, deductibles, co-insurance and any balance remaining after receipt of insurance payment.

CANCELLATION AND MISSED APPOINTMENTS

Our goal is to provide quality medical care in a timely and professional manner. In order to accomplish this, we have a cancellation and missed appointment policy. This policy enables us to more efficiently utilized our resources to better serve our patients, provide you with the very best medical care, and accommodate most appointment requests.

As all medical services are provided by appointment only and that time is reserved for your exclusive use, we request 24 hours notice via phone call to 281-412-6700 to cancel an appointment.

There is a fee of $25 for missed appointments and/or cancellations made less than 24 hours in advance.

PAYMENT OPTIONS

Pear Tree Medical Associates offers the following payment options:

1. Payment in full on the day the service is provided
2. Payment of co-payment, co-insurance or deductible on the day service is provided
3. Payment of co-insurance, deductible or amount denied by insurance upon receipt of statement.

For your convenience, Pear Tree Medical Associates accepts cash, MasterCard, VISA or Discovery Cards. If additional financial counseling is needed please contact the Business Office at 281-412-6700

I have read, understand, and agree to the financial policy as stated above. I hereby authorize payment of medical benefits to Pear Tree Medical Associates for any service furnished me by that provider. I authorize physician and clinic to release any information to process insurance claims. This authorization is in effect indefinitely unless revoked in writing.

Patient Signature:____ Date:______________________

HIPAA Information and Consent Form

The Health Insurance portability and Accountability Act (HIPPA) provides safeguard to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is available in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
4. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
5. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
6. We agree to provide patients with access to their record in accordance with state and federals laws.
7. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
8. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I,____date___________do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Patient Records Release Form

Patient Name (please print): ____________________________ Other Names Used: _______________________

Date of Birth:______________________________ Your Phone Number: ____________________________

I authorize the release of my medical records:

From: (doctors name, address and phone number): ____

To: Pear Tree Medical Associates
Isabelle Jeffress, M.D.
6302 Broadway, Suite 130
Pearland, Texas 77584
Phone: 281-412-6700 Fax: 281-412-6701

Select Purpose: O Continuation of Medical Care, O Relocation, O Changing of PCP, O Billing, O Other:____________

Request: Please send the past 2 years of clinical notes and lab reports, and the past 5 years of x-rays, diagnostic tests and operative reports. Additionally, I especially request records regarding: _____________________________________

I understand and agree to the following:

- The purpose of this release is for on-going medical care.
- The recipient of these records cannot transfer them to another party without consent from me (or authorized representative), except for purposes of treatment, payment or operations.
- Unless specifically requested, we will only release records generated by Pear Tree Medical Associates
- This authorization will expire in 60 days and can be revoked in writing at any time.
- General medical records sometimes contain reference to drug use, alcohol use, rehabilitation treatment, psychiatric treatment, sexual abuse, and other sensitive issues. I agree to release these records.
- I have read all of this release and any questions or concerns of mine have been answered.

Patient Signature:____**Date:**___________________

Additional Release: I further authorize that all psychiatric, drug, alcohol, Acquired Immunodeficiency Syndrome (AIDS) or HIVIHTLV test results/records be released to the above. In accordance with Texas State Law you are required to state the PURPOSE of RELEASE of HIV/HTLV test results/records. Purpose: _____________________________________

The HIVIHTLV test results may be released from ______________ up to and including _________________________

Patient Signature:____**Date:**___________________

Please return a copy of this patient authorization with records

Patient History Form

Please complete this sheet by filling in the bubbles completely where appropriate.

Patient Name ________________________________

Date of Birth _________________________________

PAST MEDICAL HISTORY SECTION

Please select "Yes" for any condition you have or have had in the past. Please color in the complete bubble so our computer can understand your answer. A fully completed bubble looks like this: ● Yes

Hearing Loss	O Yes	Abnormal Vision	O Yes	Diabetes	O Yes
Chest Pain/ Tightness	O Yes	Heart Attack	O Yes	Heart Disease	O Yes
High Blood Pressure	O Yes	High Cholesterol	O Yes	Phlebitis or Blood Clots	O Yes
Stroke	O Yes	Seizures	O Yes	Dementia	O Yes
Dizziness	O Yes	Migraines	O Yes	Anxiety / Depression	O Yes
Asthma	O Yes	Bronchitis	O Yes	Seasonal Allergies	O Yes
Arthritis	O Yes	Gout	O Yes	Kidney Disease	O Yes
Liver Disease	O Yes	Gallstones	O Yes	Stomach or Duodenal Ulcer	O Yes
Hepatitis	O Yes	AIDS/HIV	O Yes	Sexually Transmitted Disease	O Yes
Cancer	O Yes	Bone Disease (such as Osteoporosis)	O Yes	Tuberculosis or Positive PPD Test	O Yes

SOCIAL HISTORY SECTION

Please honestly answer the following questions about your current lifestyle. These questions will help us tailor a treatment plan for you.

Smoking:

- Which option best describes your smoking status:
  - O Current Smoker, O Former Smoker, O NOT a Smoker, O O O O O Unknown
- If you are a smoker, how many cigarettes a day do you smoke?
  - O 5 or less, O 6-10, O 11-20, O21-30, O more than 30
- If you are a smoker, are you interested in quitting?
  - O Yes, O Maybe, O No

Caffeine:

- Do you drink caffeinated beverages (coffee, soda, energy drinks)?
  - O Yes, O No
- If you do drink caffeine, how many caffeine drinks do you consume each day?
  - O 1 drink per day, O 2-4 drinks per day, O 5 or more drinks

Alcohol Use:

- Do you consume alcoholic beverages (like beer, wine, cocktails)?
  - O Yes, O No
- If you consume alcoholic beverages, how often do you consume them?
  - O More than once a day, O Daily, O Weekly, O Less than once a Week

Drug Use:

- Do you use recreational drugs (drugs not for a medical condition prescribed by a doctor)?
  - O Yes, O No
- If you use recreational drugs, how often do you use them?
  - O Daily, O Weekly, O Monthly, O Less than once a Month

Exercise:

- Do you exercise at least 30 minutes regularly?
  - O Yes, O No
- If you exercise, how often do you do so?
  - O Daily, O 2-4 Times a Week, O Once a Week, O Less than once a Week

Print Name: ____________________ Patient History Form

FAMILY HISTORY SECTION

Please answer the following questions about your Family History. Bubble in the box if your family member has had that condition.

Complete the table for your MOTHER

O Alcoholism	O Arthritis	O Asthma	O Birth Defects	O Cancer
O Diabetes	O Emphysema	O Epilepsy	O Heart Attack	O High Blood Pressure
O High Cholesterol	O Kidney Disease	O Mental Illness	O Migraines	O Obesity
O Stroke	O Other			

Complete the table for your FATHER

O Alcoholism	O Arthritis	O Asthma	O Birth Defects	O Cancer
O Diabetes	O Emphysema	O Epilepsy	O Heart Attack	O High Blood Pressure
O High Cholesterol	O Kidney Disease	O Mental Illness	O Migraines	O Obesity
O Stroke	O Other			

Complete the table for your SIBLINGS

O Alcoholism	O Arthritis	O Asthma	O Birth Defects	O Cancer
O Diabetes	O Emphysema	O Epilepsy	O Heart Attack	O High Blood Pressure
O High Cholesterol	O Kidney Disease	O Mental Illness	O Migraines	O Obesity
O Stroke	O Other			

Complete the table for your CHILDREN

O Alcoholism	O Arthritis	O Asthma	O Birth Defects	O Cancer
O Diabetes	O Emphysema	O Epilepsy	O Heart Attack	O High Blood Pressure
O High Cholesterol	O Kidney Disease	O Mental Illness	O Migraines	O Obesity
O Stroke	O Other			

Print Name: ____________________ Patient History Form

MEDICATIONS SECTION

Please list your current ***medications***, ***dosages*** and ***frequency*** in this table.

1.	4.
2.	5.
3.	6.

ALLERGIES SECTION

Please list your current allergies in this table.

ALLERGY	Type of Reaction	ALLERGY	Type of Reaction.
1.		3.	
2.		4.	

HOSPITALIZATIONS SECTION

Please list ANY past hospitalizations in this table.

Reason for Hospitalization	Year

IMMUNIZATIONS SECTION

Please list the date of each Immunization.

Immunization	Date	Immunization	Date
Flu Shot		Pneumonia	
Hepatitis B		Tetanus	
MMR			

COMMON TESTS SECTION

Please list the date and result of each of the following tests.

Test	Date	Result
Cholesterol Check		O Normal O Abnormal
Glucose Check		O Normal O Abnormal
Thyroid Check		O Normal O Abnormal
Lipids Check		O Normal O Abnormal
Colonoscopy		O Normal O Abnormal
Dexa/Bone Density		O Normal O Osteopenia O Osteoporosis
Mammogram (women)		O Normal O Abnormal
PAP Smear (women)		O Normal O Abnormal
PSA (men)		O 0 to 4 O Above 4

Review of Systems Form

Please complete this sheet by filling in the bubbles completely.

Patient Name ________________________________

Date of Birth ________________________________

Please select "Yes" or "No" for each condition based on what you are currently experiencing. This form is different than the Past Medical History form. In this form, we are looking for what you are experiencing now or in the recent past. This information will help us assess your current situation. Please color in the complete bubble so our computer can understand your answer. A fully completed bubble looks like this: ● Yes.

Weight Change	O Yes	O No	Fatigue	O Yes	O No	Chills	O Yes	O No
Ringing in Ears	O Yes	O No	Change in Vision	O Yes	O No	Swollen Lymph Nodes	O Yes	O No
Chest Pain	O Yes	O No	Heart Palpitations	O Yes	O No	Shortness of Breath	O Yes	O No
Blood in Stool	O Yes	O No	Change in Bowel Habits	O Yes	O No	Acid Reflux	O Yes	O No
Bruising	O Yes	O No	New/Changing Skin Lesion	O Yes	O No	Rash	O Yes	O No
Sleep Disturbance	O Yes	O No	Cold Intolerance	O Yes	O No	Heat Intolerance	O Yes	O No
Memory Loss	O Yes	O No	Weakness	O Yes	O No	Trouble with Balance	O Yes	O No
Snoring	O Yes	O No	Persistent Cough	O Yes	O No	Wheezing	O Yes	O No
New Allergy	O Yes	O No	Sinus Congestion	O Yes	O No	Sneezing	O Yes	O No
Attention Deficit	O Yes	O No	Eating Disorder	O Yes	O No	Anxiety	O Yes	O No
Women Only								
Abnormal Vaginal Discharge	O Yes	O No	Irregular Menses	O Yes	O No	Breast Lumps or Discharge	O Yes	O No
Men Only								
Difficulty with Erection	O Yes	O No	Testicular Pain or Swelling	O Yes	O No	Urination Urgency or Frequency	O Yes	O No

6302 Broadway, Suite 130
Pearland, TX 77581

www.peartreemedical.com

Phone: 281-412-6700