HEALING HEARTS

Please read all instructions.

Please fill out entirely.

Please print, fill out and email to

appointments@healingheartsclinic.com

You can also fax if preferred:

936-539-9685

Please return to our office at least **TWO days** prior to your appointment or we you will have to reschedule.

HEALING HEARTS

REGISTRATION FORM - (PLEASE PRINT)

Date:	**PCP's Last** name:	First:	Middle:	PCP Ph:	

PATIENT INFORMATION

Patient's last name:	First:	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
Race:	Ethnicity:	Religion Preference:			
Email:		Language:			Interpreter Needed: ❑ Yes ❑ No
Street address: Apt #		Social Security:			Home ph: Cell ph: Work ph: To which # do you wish to receive appointment reminders?
P.O. Box:	City:	State:	ZIP Code:		
Employment Status: ❑ Full Time ❑ Part Time ❑Unemployed ❑ Student ❑ Other:		Employer:			Employer ph: ( )
Pharmacy's Name		Pharmacy's Ph: ( )			
How did you hear about us:					

INSURANCE INFORMATION

(Please give your insurance card & ID to the receptionist)

Person responsible for bill:	Birth date:	Address (if different from patient):	Home ph: Cell ph:
Occupation:	Employer:	Employer address:	Employer ph: ( )

PRIMARY INSURANCE	SECONDARY INSURANCE
Name of primary insurance:	Name of secondary insurance :
Subscriber's name:	Subscriber's name:
Subscriber's S.S.:	Subscriber's S.S.:
Birth date:	Birth date:
Group:	Group:
Policy#:	Policy #:
Co-payment: $ _____	Patient's relationship to subscriber: ❑ Self ❑ Child ❑ Spouse ❑ Other
Patient's relationship to subscriber: ❑ Self ❑ Child ❑ Spouse ❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home ph: ( ) Work ph: ( ) Cell ph: ( )

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 my insurance company to release any information required to process my claims. I acknowledge receipt for the notice of privacy policies and practices of this clinic.

Patient/Guardian signature *Date*

New Patient Questionnaire

Please take a few moments to fill out the following information sheet so that we may care for you more efficiently and comprehensively. These forms will be completed at your first visit only.

Name:_____DOB:_____

Home Phone:_____Cell:_____Work:_____

E-mail:_____Primary Care Physician:_____

List all Medical Problems/Conditions, Past and Present:

1._____ 6._____

2._____ ?._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

List all Surgeries {Include year):

1_____

2._____

3. _____

4._____

5. _____

List Other Hospitalizations (include year):

1_____

2._____

3. _____

4._____

5. _____

Current Medications and Dosages:
{Include herbs, vitamins, and over the counter)

1._____

2. _____

3._____

4. _____

5. _____

List Medication Allergies:
(Include reaction type)

1_____

2. _____

3._____

4. _____

5> _____

Name: _____DOB: _____

Have you ever….

Had a problem with alcohol or drug abuse: Yes ☐ No☐_____

Check all that apply:

Smoke: ☐No If yes, Amount/day_____ Number of years:_____

Alcohol: ☐No If yes, Amount/Day _____ Illicit Drugs: ( ) No If yes, Type_____

Caffeine: ☐No If yes, Amount/Day _____

Exercise: ☐Never ☐1---2 Days/Week ☐3---7 Days/Week

☐Married ☐Single ☐Divorced ☐Engaged ☐Widowed

Name of Spouse/Significant Other: _____ Number of years together:_____

Their Occupation:_____ Your Occupation: _____

Family History

Mother: If living, Age:_____

Health Problems:_____

If deceased, cause of death: _____

Father: If Living, Age:_____

Health Problems: _____

If deceased, cause of death: _____

Have you had any relatives with the following: (If yes, list relation)

Diabetes:_____

Heart Disease: _____

High Blood Pressure: _____

Stroke: _____

Osteoporosis: _____

Cancer: _____

Breast_____ Ovary_____ Colon:_____

Other:_____

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