Thrive Medical Clinic

2217 Park Bend Dr Suite 210
Austin, TX 78758
Phone: 512-697-7090 | Fax: 512-697-7097

Patient Registration Form

Today's date:			
PATIENT INFORMATION			
Patient's last name:	First:	Middle:	Marital Status: Single/Mar/Div/Wid/Other
Email Address:		Birth Date:	Sex:
Street address:		Social Security no.:	Home phone no.:
City:	State:	ZIP Code:	Cell phone no.:
Occupation:	Employer:		Employer phone no.:

Preferred Language: ❑ **English** ❑ Spanish ❑ Other:

Ethnicity: ❑ Hispanic or Latino ❑ **Not Hispanic or Latino**

Race: ❑ American Indian or Alaska Native ❑ **Asian** ❑ Black or African American
❑ Native Hawaiian or Other Pacific Islander ❑ White

Gender Identity: ❑ **Male** ❑ Female ❑ Transgender Male ❑ Transgender Female ❑ Genderqueer
❑ Other _____ ❑ Decline to Answer

Sexuality: ❑ **Heterosexual** ❑ Homosexual ❑ Bisexual ❑ Something else : _____ ❑ Don't Know ❑ Decline

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Name of primary insurance:		
Group #	Policy #:	
Name of secondary insurance (if applicable):	Group #:	Policy #:

I, the undersigned authorize payment of medical benefits to ***Thrive Medical Clinic*** for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided by me. This information will be used for the purpose of evaluating and administering claims of benefits.

Patient/Guardian signature _____ **Date** _____

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Additional Information

1. **In case of an emergency**, please notify:

   Name: _____ _____ Phone Number: _____

   Relationship to patient: _____

   May we inform this person of confidential information? YES ☐ **NO** ☐

2. Can confidential messages be left on your:

Home telephone answering machine:	☐ Yes	☐ No
Cell phone voicemail:	☐ Yes	☐ No
Work voicemail:	☐ Yes	☐ No
Personal Email	☐ **Yes**	☐ No

3. Preferred method of contact: _____
4. Do you have a LIVING WILL? ☐ Yes ☐ **No**
5. Do you have a Medical POWER OF ATTORNEY? ☐ Yes ☐ **No**

   If yes, Name _____ Number _____

6. Next of kin name: _____ Phone number: _____ Relationship to patient: _____
7. Pharmacy Information:

   Preferred Pharmacy: _____ Pharmacy Phone #: _____

   Pharmacy Address: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have reviewed the Notice of Privacy Practices for Thrive Medical Clinic, which explains in plain language how my protected health information (PHI) will be used and disclosed, my individual rights, and the practice's legal duties with respect to my PHI. I understand that I am entitled to receive a copy of this information upon request.

Signature ____ _____ Date _____

Release of Medical Records

I am requesting that the medical information be transferred to **Thrive Medical Clinic**

I understand that the information in my or my child's health record may include information relating to STD, AIDS, or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Signature _____ Date _____EXP: _____

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REASON FOR TODAY'S APPOINTMENT:

_____

PAST MEDICAL HISTORY
Please list all past medical history:

_____

_____

PAST SURGICAL HISTORY
Please list all past surgical history (please include year):

_____

_____

PAST FAMILY HISTORY
Please list any family history (please include maternal/paternal relationship to patient):

_____

_____

MEDICATIONS
Please list all medications currently taking, please include dosage:

_____

_____

ALLERGIES
Please list current drug allergies and reaction to medication:

_____

Please circle allergy severity: ***VERY MILD*** ***MILD*** ***MODERATE*** ***SEVERE***

TOBACCO USE *(Circle one)*

Smoke, # of cigarettes per day _____ Chew ☐ Former smoker, Date Quit _____ Never Smoker ☐

ALCOHOL USE *(Circle one)*

Yes, Amount per week _____ No ☐

DRUG USE *(Circle one)*

Yes, Type and frequency _____ No ☐

How many children do you have? _____ **None** ☐

PREVENTATIVE

Last Colonoscopy:_____ **Last Pap Smear:**_____ **Last Mammogram:** _____