Dear New Patient:

Welcome to our practice! We are very pleased that you have selected us for your medical care. Enclosed are forms for you to fill out prior to your appointment to help assist our office staff and your provider in making sure that we have all the necessary information to provide you with the quality of care and treatment you deserve. Listed below are some helpful hints to make sure your visit goes as smooth as possible.

- Our providers try very hard to stay on time with their patients, but sometimes medical emergencies do occur which can cause them to run behind. You can do your part by kindly checking n 15 minutes prior to your appointment to help prevent delays.
- For all appointment, please bring all medications, supplements, vitamins, etc. in the original bottle to your appointment so we can verify dosage and fill date and ensure accuracy.
- Insurance cards, picture ID, and co-pay are required at every visit.
- We offer a secure patient portal where you can view your medical history, results, send a message to your provider, receive and pay statements online.
- If you cannot make it to your scheduled appointment, we ask that you give us at least a 24 hour notice.
- To initiate a medication refill request, please call your pharmacy and allow 72 business hours for the pharmacy to contact our office and the refill process with begin
- Our onsite lab hours are 7:30-4:00pm (closed for lunch 12:00pm-12:45pm)

Deer Park Family Care Clinic is committed to quality care and meeting our patients needs. We also offer visiting specialist such as cardiology, mental health, and chiropractic services.

Once again, welcome to our practice

Cordially,

Deer Park Family Care Clinic

DPFCC New Patient

Name: _____DOB: ____/____/_____

SSN: _____ Marital Status: Single Married Divorced Widowed Separated

Race: _____ Ethnicity: Hispanic Non-Hispanic Sex: Female Male Unspecified

Email Address: _____

Physical Address: _____

City:_____State_____Zip_____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Guarantor (Person financially responsible for account) First Name: _____Last_____

DOB: _____/_____/_____ SSN: _____-_____-_____ Sex: Male Female Unspecified

Emergency Contact: _____ Number: _____ Relationship_____

Insurance Information

Subscriber Name: _____Sex: Male Female Unspecified DOB: ____/_____/_____

Insurance Company: _____ ID# _____Group# _____

Release of Information to Spouse/Relatives/Friends and HIPAA Notice

A give permission for these specified persons to obtain/request/discuss any of my appointments/prescriptions/medical/billing information during the duration of my time here as a patient at Deer Park Family Care Clinic. I understand that any time during this period I can revoke the privileges to the assigned names below and I will inform DPFCC staff of any deletions or additions to the persons allowed to receive this information. Once health care information is disclosed, the person that receives it may re-disclose it, and privacy laws may no longer protect it. This contract will **expire in one year** and will need to be filled out and updated one year from the signed date.

***Any information I do not want disclosed (STD, substance abuse, mental health information, HIV, pregnancy, sterilization or other information) will be written in the comment section below. If you would like a copy of the HIPAA privacy policy please ask at the front desk.**

Name: _____Phone: _____Relation: _____

Name: _____Phone: _____Relation: _____

Name: _____Phone: _____Relation: _____

Comments:

_____

_____

Would you like us to leave detailed messages on your primary phone number answering machine? Yes No

I certify that all information is true and correct. I authorize the release of any necessary information, including medical information, for this or any related claim, to the insurance carrier and primary doctor. In making this assignment, I authorize payment to be made directly to Deer Park Family Care from my insurance company. I understand and agree that I am financially responsible for co-pays and deductibles at the time of service. Any charges not paid by the insurance company will become my responsibility and is due immediately.

_____ _____

Signature of person financially responsible **Date** **Accepted**

Name: _____ MRN:_____

Main reason for today's visit

- _____
  _____

Other concerns I would like to discuss if there's time available:

- _____

Please check all that apply:

___ I have prescriptions that need to be refilled

___ I need a school or work excuse

___ I need the attached forms filled out

___ Other

Please list known **Allergies** and what reaction you have to them:

_____
_____
_____

Please list all prescriptions and over the counter **Medications** and doses (if you have a list of your medications we can copy it for you):

Medications Dose Frequency

_____
_____
_____
_____
_____

Please list all **Surgeries** and any complications:

_____
_____
_____

Surgical History: please list all prior surgeries and approximate dates performed:

_____ _____

_____ _____

Name: _____ MRN:_____

Personal History (please mark all that apply)

	You	Family		You	Family		You	Family
ADHD			Diverticulitis			Liver disease		
Alcoholism			DVT			Macular Degeneration		
Allergies			GERD			Neuropathy		
Anemia			Glaucoma			Osteopenia/osteoporosis		
Arrhythmia			Heart Disease			Parkinson's disease		
Bipolar			Heart Attack			Peptic Ulcers		
Bladder problems			Hiatal hernia			Pulmonary Embolism		
Bleeding problem			High blood pressure			Rheumatoid Arthritis		
Cancer			Kidney stones			Seizure Disorder		
Headaches			Kidney disease			Sleep apnea		
Chron's disease			High Cholesterol			Stroke		
COPD			HIV			Thyroid Disorder		
Dementia			Hepatitis			Ulcerative Colitis		
Depression			Irritable Bowel					
Diabetes			Lupus					

Personal History (please mark all that apply)

other medical problems that are not listed above:

_____ _____

_____ _____

Social/cultural history:

Current Living situation (check all that apply)

Single family Household Multi-generational household Homeless

Shelter Skilled nursing facility Other_____

Do you drink alcohol? **Y / N** _____drinks/day _____ drinks/week x_____years

Do you smoke/Vape/ **Y /N** _____pack/day x _____years

Recreational drugs including marijuana? **Y / N** _____ Type_____

Are you sexually active? **Y /N** preference men____ Women____ no preference____

Are there any personal problems or concerns at home, work, or school that you would like to discuss? **Y /N**

Are there any cultural or religious concerns you have related to the type of care? **Y/ N**

Are there any financial issues that directly impact your ability to manage your health? **Y/N**

Name: _____ MRN:_____

Comments (please feel free to comment on any answers above)

_____

_____

Preventative screenings

Last menstrual period	Date Period began:	Normal/Abnormal
Colonoscopy	Yes/No Date:	Normal/Abnormal
Mammogram	Yes/No Date**:**	Normal/Abnormal
Dexa Bone Density Scan	Yes/No Date**:**	Normal/abnormal
Pap smear	Yes/No Date**:**	Normal/ Abnormal
Prostate Cancer Screening	Yes/No Date**:**	Normal/Abnormal

Vaccines

Tetanus	Date**:**	Where:
Pneumonia 13	Date**:**	Where:
Pneumonia 23	Date:	Where:
Flu	Date**:**	Where:
Shingles	Date:	Where:

Have you seen another physician/provider or **specialist** recently, and if so which physician/provider and when?:_____

_____

_____

I certify that all the above information is true and correct to the best of my knowledge. I give my permission to physicians and staff at the Deer Park Family Care Clinic to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my medical problem.

Patient Name: _____

Signature of Patient: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____