GILCREASE MEDICAL GROUP
Patient Information

Patient Name:_____ Date of Birth:_____

Address: _____ City:_____ State:_____ Zip:_____

Home#:_____ Cell#:_____ Work#:_____

Sex: M___F___ Drivers'License#:_____

Marital Status: Married____Single____Divorced____Separated____

Employer Name: _____ Phone #: _____

Address: _____ City: _____ State: ____ Zip: _____

Patient Email Address:_____ Emergency Contact Name:_____

Home#:_____ Cell#:_____ Work#:_____

PREFERRED PHARMACY: _____

INSURANCE INFORMATION (TO BE COMPLETED BY PATIENT)

Primary Insurance: _____ Policy#: _____ Grp#:_____

Policy Holder:_____ Phone #:_____

Address:_____ City: _____ State____ Zip_____

Date of Birth:_____ Social Security #:_____ Relationship:_____

Co-Pay:_____ Deductible:_____

Secondary Insurance:_____ Policy#:_____Grp#:_____

Responsible Party:_____ Telephone #: _____

PAYMENT IS DUE AT THE TIME OF SERVICE

I request and authorize the doctors and staff of Gilcrease Medical Group to care for me and/or my family members. I agree to be personally responsible for payment for services rendered.

SIGNATURE:_____ DATE: _____

Name: _____ **DOB:** _____ **Date:** _____

My Medications: List names and strengths of all prescribed and non- prescribed medications you take and how often you take them?

Medication	Strength	How often taken?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

My Allergies or Side Effects to Medications: List medications that you are allergic to and the reaction you have.

My Medical History: Check all problems you have been diagnosed with and enter year diagnosed. Write in any problems that are not listed.

	Problem	Year
	Acid Reflux (GERD)	
	Anxiety	
	Arthritis	
	Asthma	
	Cancer	
	COPD	
	Depression	
	Diabetes	
	Gout	
	Heart Disease	
	High Blood Pressure	
	High Cholesterol	

	Problem	Year
	High/Low Thyroid	
	Insomnia	
	Kidney Disease	
	Menopause	
	Migraines	
	Neck/Back Pain	
	Seasonal Allergies	
	Seizures	

My Surgeries: Check all surgeries you have had and enter the year. Write in any surgeries that are not listed.

	Procedure	Year
	Tonsils	
	Appendix	
	Gall Bladder	
	GYN	
	Vasectomy	

	Procedure	Year

My Family History: Simply mark appropriate box with an "X". Write in Problem if not listed.

Problem	M	MGM	MGF	MC	F	PGM	PGF	PC	Bro	Sis	Other
High Blood Pressure											
Diabetes											
Heart Attacks											
Cancer											

Legend: M=Mother F=Father Bro=Brother Sis=Sister MGM= Maternal Grandmother MGF= Maternal Grandfather MC=Maternal Cousin

PGM= Paternal Grandmother PGF= Paternal Grandfather PC= Paternal Cousin

My Cardiac Risk Factors: Simply mark appropriate box with an "X".

	No	Yes
Are you a Male over 50 years or a Female over 55 years of age?		
Did anyone in your family have a heart attack before the age of 50?		
Have you ever been diagnosed with Diabetes?		
Have you ever been diagnosed with High Blood Pressure?		
Have you ever been diagnosed with Low HDL (good Cholesterol)?		
Have you ever smoked or dipped tobacco?		

Note: The number of "Risk Factors" determines what your target LDL should be!

0 factors = LDL of <160
1-2 factors = LDL of <130
>2 factors = LDL of <100

My Menopause History (Females Only): Simply mark appropriate box with an "X".

Problem	Self No	Self Yes		Family No	Family Yes	Family Member
Breast Cancer						
Colon Cancer						
Blood Clot in legs (DVT)						
Stroke						
Osteoporosis						

My Health Maintenance: Leave items blank if it does not apply to you.

For All	Month/Year
For Example: May ,2013	5/2013
When was your last Physical (Annual) Exam?	
When was your last vaccine of:	
Tetanus or Whooping Cough (Td, TDap)	
Pneumonia (Pneumovax 23)	
Pneumonia (Pneumovax 13)	
Shingles (Varicella, Zostavax, Varivax)	
HPV (Gardasil)	
Flu	
For Women Only:	
Bone Density	
Mammogram	
Pap Smear	
For Men Only:	
Prostate Level Blood Test (PSA)	
For those over 50 years of Age:	
Colonoscopy	
Stool Cards to test for blood in stool	

For those with the following diagnosis:	Month/Year
Diabetes:	
Your last HgbA1C	
Your last Annual Eye Exam	
Your last Annual Foot Exam	
Your last Micro albumin	
High Blood Pressure (Hypertension):	
Your last EKG	
Your last Stress Echo	
Asthma:	
Lung Function test(aka: Spirometry)or PFT	
Elevated Liver Enzymes or Hepatitis:	
Your last Hepatitis A Vaccine Series.	
Your last Hepatitis B Vaccine Series.	
History of Smoking Tobacco:	
Your last Chest X-Ray	

My Social History: Circle appropriate item under each category.

Marital Status:	Alcohol:	Tobacco:
Single	Never	Never
Married	Socially	Socially
Divorce	Frequently	Previously
Widowed	Daily	Daily
Significant Other		

My Specialists: List all specialists you are currently seeing.

GILCREASE MEDICAL GROUP

135 Bunton Creek Rd, Suite 102
Kyle, Texas 78640
(512) 268-2091
Fax (512) 268-2190

FINANCIAL RESPONSIBILITY

Payments for medical services are due from the patient at the time of service. Payment may be made with cash, check, money order, and credit or debit card. Patients covered by an insurance plan with which the clinic has an agreement are to pay their co-pay on the day of service. The practice will then electronically bill the insurance company the unpaid amount for the services provided to you or whichever patient is also covered by the plan and is being treated. Patients not covered by one of our participating insurance plans will be requested to pay the estimated services on the day the services are provided. Under certain circumstances written financial arrangements can be made.

When being seen by one of the providers of the practice the patient may be asked monthly to provide a copy of their insurance card and driver's license to verify information. Additionally, it is the patient's responsibility to make sure the office has current address information and phone numbers when being seen. It is a HIPAA requirement that an acceptable form of identification be presented to ensure that the patient being treated is properly identified.

Balances remaining after payment from the primary insurance plans will be billed to the secondary insurance plan by the practice. Any remaining balances become due within thirty (30) days after the insurance plans have paid or have denied the claim. The practice does not accept Medicaid, new CHIP patients and some Medicare Advantage programs.

Failure to respond appropriately to any outstanding financial indebtedness or responsibility could interfere with the patient seeing the provider for their scheduled appointments.

MEDICARE PATIENTS: Gilcrease Medical Group accepts Medicare assignment. As a courtesy the practice will bill a secondary insurance company once Medicare pays the claim. After Medicare has paid and the secondary insurance also pays or denies payment, the patient will be billed for the balance which is to be paid within thirty (30) days of the statement date.

I hereby acknowledge receipt of this information and agree to abide by the policies of the practice.

Date:

Patient name (printed): _____

Patient signature: _____

The patient may sign the general consent form which acknowledges that this information has been provided to them and that they agree to the terms and policies of the practice

GILCREASE MEDICAL GROUP

OFFICE RELEASES AND POLICIES

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 or practice. I also authorize the provider to release any information required to process this claim to my employer, prospective employer and/or insurance carrier.

X Signed: _____ Date: _____

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

X Signed: _____ Date: _____

FINANCIAL OBLIGATION: I hereby acknowledge that I understand that there may be services provided which are 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 and I may be billed for such related services subsequently. I also understand that I am expected to provide a current copy of my insurance card at the time of service or the appointment may be rescheduled or delayed.

X Signed: _____ Date: _____

CONSENT FOR TREATMENT: I hereby authorize the provider, medical assistants and staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable for the condition for which I am being examined.

X Signed: _____ Date: _____

HIPAA CONSENT: I have received a copy of the Health Insurance Portability and Accountability Act. I also understand that it is a HIPAA requirement to provide a pictured ID at the time of service unless one is already on file that could be used for identification. The following is a list of the names of people with whom I agree to have my Protected Health Information released to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

X Signed: _____ Date: _____

NO SHOW POLICY: Patients who fail to present for a scheduled appointment without contacting the practice to cancel the appointment within 24 hours prior to the appointment will be considered "no show". Patients who consistently fail to present for scheduled appointments will be considered "chronic no shows". A "chronic no show" is defined as having 3 missed appointments in a rolling 12 month period. Patients will be notified of the "no show" policy at the time of registration. Patient appointment status will be updated in our schedule software as a "no show". On the 3rd missed appointment the patient is billed $25.00 and may possibly be sent a letter discharging them from the practice and shall be blocked from scheduling another appointment. Discharging a patient from the practice is a decision of the provider.

I have read and understand the above stated policy.

X Signed: _____ Date: _____

ADVANCED DIRECTIVES: All patients based upon government guidelines are to be offered the opportunity to request "Advanced Directive" to be placed in their medical records in the event that and untoward event should occur which renders them incapable of making clinical judgements on their own. In the event that the patient desires to complete an Advanced Directive, the front office staff shall offer a sample "Advanced Directive" form to be completed by the patient and signed.

I have been asked about whether I have or would like to have an "Advanced Directive" placed in my medical records to direct the provider about decisions made on my behalf in the event that I become incapable of making those decisions.

X Signed: _____ Date: _____