SMART CHOICE
HEALTH AND WELLNESS CLINIC

# PATIENT REGISTRATION

**LAST**_____**FIRST**_____**MI**_____

**DOB**_____

**ADDRESS:** _____

**CITY:** _____**STATE:** _____ **ZIP:** _____

**HOME PHONE NUMBER:** _____

**CELL PHONE NUMBER:** _____

**EMPLOYER**_____

**ADDRESS**_____

**WORK PHONE NUMBER:** _____

**EMERGENCY CONTACT**_____

**EMERGENCY CONTACT NUMBER**_____

**EMERGENCY CONTACT**_____

**EMERGENCY CONTACT NUMBER**_____

**REASON FOR VISIT**_____

_____

_____

**DATE OF ONSET OF SYMPTOMS:** _____

SCHWC, 9025 Sam Houston Pkwy E, Ste 105, Humble, TX 77396 Ofc 832-777-1467 Fax: 832-777-1454
www.smartchoicehwc.com

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# PATIENT REGISTRATION

**CURRENT MEDICATIONS: Please list all prescription and non-prescription medications including vitamins and supplements. (List dosage and how often).**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

**ARE YOU PREGNANT? YES_____ NO_____**

**DATE OF YOUR LAST MENSTRUAL CYCLE?_____**

**LIST ALL CURRENT AND PAST MEDICAL HISTORY:**

**Arthritis_____ Asthma_____ Bone/Joint Disease_____ Cancer_____**

**Chest Pain_____ COPD_____ Depression/Anxiety_____ Diabetes_____**

**Gastritis/Ulcer_____ Gout_____ Headaches_____ Heart Disease_____**

**Hepatitis_____ High Blood Pressure____ HIV_____ Prostate Disease_____**

**Other Medical History_____**

**Allergies_____**

**Any Known Medication(s) Allergies_____**

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# PATIENT REGISTRATION

**HAVE YOU HAD SURGERY IN THE PAST? NO_____ YES_____ (if yes list below)**

**TYPE/DATE_____**

**TYPE/DATE_____**

**TYPE/DATE_____**

**TYPE/DATE_____**

**FAMILY HISTORY: (Check all that apply)**

**ALZHEIMER____ ARTHRITIS____ CANCER____(type)_____**

**GOUT____ HEART DISEASE____ OSTEOPOROSIS____ STROKE____**

**OTHER_____**

**DO YOU SMOKE/CHEW TOBACCO? YES____ NO____**

**CIGARETTES PACKS/DAY____ CIGARS PER DAY____**

**DO YOU USE RECREATIONAL DRUGS? YES____ NO____**

**IF YES, TYPE_____**

**DO YOU DRINK ALCOHOLIC BEVERAGES? YES____ NO____**

**IF YES, HOW OFTEN? SOCIALLY____ RARELY____ DAILY____**

**HOW DID YOU HEAR ABOUT SMART CHOICE HEALTH AND WELLNESS CLINIC?**

**_____**

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## FINANCIAL AGREEMENT

Payment is due in full at the time of service. Acceptable methods of payment are cash, debit and/or credit card. _____ (please initial)

I understand that my insurance policy is a contract between myself and my insurance company; Smart Choice Health and Wellness Clinic is not involved in billing to your insurance company. If I have questions or concerns regarding my coverage for office visits, procedures, lab work, medications, or particular conditions, I am responsible for obtaining this information. **I agree to pay in full for all services.** _____ (please initial)

## HIPAA

Smart Choice Health and Wellness Clinic upholds the standard of the HIPAA laws. As a patient, we want you to know:

- We respect the privacy of your personal medical records and will do all we can to secure and protect that privacy.
- When it is appropriate and necessary, we provide the minimum information to only those in need of your health care information, treatment, payment or health care operations, in order to provide health care that is in your best interest.
- You may refuse to consent to the use or disclosure of your personal health information, but *this* **must be in writing**.
- Under this law, we have the right to refuse to treat you should you refuse to disclose your Personal Health Information (PHI). This information is critical in making appropriate medical decisions.

## TREATMENT CONSENT AND AUTHORIZATION

I consent to medical screening and medical examination to determine my current health status, other medical evaluations, diagnostic procedures, routine care, and medical treatments which the medical and professional staff of Smart Choice Health and Wellness Clinic may deem necessary, advisable, or appropriate. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of the procedures and/or treatments.

**I have read the above information and consent that it is correct to the best of my knowledge. My signature here indicates compliance with the above policies.**

_____ _____

**Signature of Patient/Guardian** **Date**

**Note:** If you have any questions regarding this consent, please speak with the front desk staff. Thank You.

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