WISEMAN FAMILY PRACTICE
Integrative Medicine and Total Wellness

PATIENT REGISTRATION INFORMATION

Please PRINT and COMPLETE ALL SECTIONS Below

Patient's Information

Name: ______________________________ ______________________________ ______________
Last Name First Name Middle Initial

Date of Birth: _____ / _____ / _____ Social Security #: _____ - ____ - _____ Email: ______________________________

Address: ______________________ Apt. # ______ City: __________________ State: ______ Zip: ___________

Home Phone: (____)________________ Cell Phone: (____)______________ Work Phone: (____)________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex: ☐ Male ☐ Female

Race: ☐White ☐Black/African American ☐Asian ☐Other Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Declined

Insurance Information

(*Please present insurance card(s) to receptionist at check-in.*)

PRIMARY Insurance Name: __________________________________ Phone: (____)____________________

Address: _________________________________ City: __________________ State: ______ Zip: _________

Name of Insured: ______________________ Date of Birth: ____________ Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other

Policy Holder #: _____________________________ Group #: _________________ Co-Pay: $____________

Person Responsible for Account: ___________________________ Relationship: ___________________________

Person Responsible: Date of Birth: _______ / _______ / _________ Social Security #: _______ - _______ - _________

Policy Holder's Address (if different from above): ____________________ City: ___________ State: ___ Zip: _________

Home Phone: (____)________________ Cell Phone: (____)______________ Work Phone: (____)________________

Pharmacy Information

Pharmacy Name: ___________________________ Phone: (____)_____________ Fax: (____)_______________

Address: ________________________________ City: __________________ State: ______ Zip: ___________

Emergency Contact

Name: ___________________________________ Relationship: ___________________________________

Address: ___________________________ City: _______________________ State: ______ Zip: ___________

Home Phone: (____)________________ Work Phone: (____)______________ Cell Phone: (____)________________

Referral Source: Whom may we thank for referring you to our practice? ☐Internet ☐Magazine: ____________________
☐Another Patient: ______________________ ☐Other: ____________________________

Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly the Wiseman Family Practice, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize Wiseman Family Practice to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: ____ Date: ____________________________

WISEMAN FAMILY PRACTICE
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OFFICE POLICIES &
CONTACT PERMISSION
Please PRINT and COMPLETE ALL SECTIONS Below

Dear Patients:

OFFICE POLICIES: Because we are subject to the increasing demands of managed care, it has become necessary to alter our office policies. Our office policies are as follows:

1) ***24-hour notice of appointment cancellation*** is necessary to assure our patients of appointment availability. Too often, appointments are missed but not cancelled, causing valuable appointment space to be lost. To minimize this problem, ***we are instituting a $25.00 "No Show Fee"*** which you will be billed for, should you fail to cancel your appointment within 24 hours.

2) ***Return phone calls***. As our providers see numerous patients during the day, it is very difficult for them to return phone calls during regularly scheduled hours. We ask that you allow up to 24 hours for us to return your phone calls with the exception of emergencies. In addition, we do not bill for any phone calls as it is a courtesy to our patients. ***If you are experiencing a life-threatening situation, please call the emergency room for immediate assessment***.

3) ***Late arrivals***. Patients that arrive late for their scheduled appointment will be seen as soon as possible. However, should another patient with a scheduled appointment arrive at the same time, they will be seen first.

4) ***We file insurance*** as a contractual agreement and as a courtesy. However, if we do not receive payment from the insurance company within 90 days, it then becomes the patient's responsibility, and the patient will be billed. Although we are not a Medicare provider, we will file your paperwork. Full fees are due at time of appointment. After filing your paperwork, you should receive a reimbursement from Medicare within 30-45 days.

EMAIL: In order to provide future appointment confirmations, office appointments, newsletters, educational articles, and/or other information from Wiseman Family Practice, we would like **permission** to use your email and/or your cellular telephone number. I understand that the above information will be kept private and confidential, and ***I give permission for Wiseman Family Practice to email and/or text me as needed.***

- Email Address: ________________________________ Cell Phone: __________________________
- Printed Patient Name: _______________________________________
- Patient Signature: ____
- Date of Birth: ____

I, ____, have read and understand the policies described above.

Signed: ____ Date: ______________________________

Patient Portal Information (FOR OFFICE USE ONLY)
Username:______________________________
Password:_______________________________

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA)

Please PRINT and COMPLETE ALL SECTIONS Below

Patient Name: ____

Home Address: ____

Phone: ______________________________ **DOB:** ________________

By my signature below, I hereby authorize Wiseman Family Practice ("Practice") to disclose my protected health information (PHI) so that the Practice may treat me, seek payment from third parties for such treatment, and generally carry on the Practice's treatment, payment and health care operations (TPO), (e.g., quality assurance). I also authorize the Practice to disclose my medical information to insurers and providers outside of the Practice when necessary so that these providers may treat me, seek payment for that treatment, and for the purpose of their health care operations.

With this consent, Wiseman Family Practice may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, such as appointment reminders, insurance issues, and any calls pertaining to my clinical care, including laboratory results.

With this consent, Wiseman Family Practice may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient financial statements. Please check your preferred contact method.

☐ Email/Patient Portal ☐ Mail ☐ Phone

With this consent, Wiseman Family Practice may speak with the following. List family members, friends, etc. whom you would like to have access to your protected health information to assist the practice in carrying out TPO, such as discussing any open or unpaid balance of my financial account, including visit reason, insurance-related matters, or any other medical issues.

Name: ________________________________, Relationship

Name: ________________________________, Relationship

I have the right to request that Wiseman Family Practice restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Wiseman Family Practice to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Wiseman Family Practice may decline to provide treatment to me.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Wiseman Family Practice reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained through our office.

I have reviewed this office's Notice of Privacy Practices (HIPAA), which explains how my medical information can be used and disclosed. I understand that I am entitled to receive a copy of this document.

Print Patient's Name: ________________________________

Signature of Patient: ________________________________

Date: ________________________________

6/12/13

PATIENT MEDICAL HISTORY

Please PRINT and COMPLETE ALL SECTIONS Below

NAME: ____ **Date**: ______________________________
DOB: ______________________________ **Reason for Today's Visit:** __________________________

____

FAMILY HISTORY:
Father's Age ___________ If deceased, age at death & cause: _____________________________________
Mother's Age ___________ If deceased, age at death & cause: _____________________________________
Total number of brothers and sisters you have had: ____
Have there been any deaths or new illnesses in your immediate family in the past year? ______________________

Have any of your blood relatives had the following: (Circle Yes or No)
1. High Blood Pressure: Yes No Relative _______________________ Age of Diagnosis ____________
2. Diabetes: Yes No Relative _______________________ Age of Diagnosis ____________
3. Heart Trouble: Yes No Relative _______________________ Age of Diagnosis ____________
   Type of Heart Trouble: ____
4. Cancer: Yes No Relative _______________________ Age of Diagnosis ____________
   Type / Location of Cancer: ____
5. Other Illness: Yes No Relative _______________________ Age of Diagnosis ____________
   Type of Illness: ____

SOCIAL HISTORY:
Age: _________________ Sex: Male / Female Marital Status: ____________________________
Education: _____________________ Occupation: ___________________________ Hours/Week? _____
No. of Children: ___________________________ Children at Home: ___________________________
Diet: ____
Exercise: Type _________________________ Frequency _________________ Duration ____________
Cigarettes Smoked per Day: ________________ Alcohol / Type: ________________________________

PAST MEDICAL HISTORY:
Any current medical problems? ____
____
Have you ever been treated for high blood pressure? Yes No At what age? _______________
Have you ever been told that you have heart trouble? Yes No At what age? _______________
What kind of heart trouble? ____
Have you ever been told that you have diabetes? Yes No At what age? _______________
What serious injuries or illnesses have you had? ____
____
What operations have you had? Please list approximate dates. _____________________________________
____
Any other physician visits in the past year? ____

- **MEDICATIONS**: List all medications and the dosage/number of pills you take per day. _______________
  ____
- **DRUG ALLERGIES**: List all medications to which you are allergic, and the kind of symptoms that you experienced.____
-
- **VITAMINS, MINERALS, AND SUPPLEMENTS**: List all that you taking. ________________________
  ____
- **IMMUNIZATIONS**: Date of last TB: ______________________
  Date of last TD (Tetanus): ________________
  Date of last Pneumonia: __________________
  Date of last (Other): ____________________

PATIENT MEDICAL HISTORY
Please PRINT and COMPLETE ALL SECTIONS Below

REVIEW OF SYSTEMS:

General: Has your weight fluctuated more than 10 pounds in the past year? ______________________________
Any unexplained fever, chills, or drenching night sweats? ______________________________

HEENT: Any significant change in vision? ______________________ Hearing? ____________________
Any pollen allergies or bad nasal drainage? ______________________________

RESPIRATORY: Any chronic cough, chest congestion or shortness of breath? ______________________________
Any coughing up of blood? ______________________________

CARDIOVASCULAR: Any chest pain, heart palpitations or irregular hear beat? ______________________________
Any edema or swelling? __________________ Any leg cramps with walking? ______________________________

GI: Any chronic or severe indigestion? ______________________________
Any pain or difficulty swallowing? ______________________ Any change in bowel habits, diarrhea, or constipation? ______________________ Any blood in your stool? ______________________________

GU: Any burning with urination? __________________ Any difficulty urinating? ____________________
Any blood in the urine? ____________________ Increased frequency of urination? ________________
Frequent night urination? ______________________________

MEN: Do you do monthly self-testicular exams? ____________ Any lumps or pain noted? ________________
Any impotence? ______________________________

WOMEN: Any vaginal discharge, discomfort, or unexpected bleeding? ______________________________
Are menstrual cycles regular? ________________ Date of last period? ____________________
Method of contraception: ________________ Date of menopause or hysterectomy? ______________
Any hot flashes? ____________________ Any pain with intercourse? ________________
Any breast pain, discharge, or lumps? __________ Do you perform self-breast exams? ______________

MUSCULOSKELETAL: Any arthritis or joint pain? ________________ Any muscle aches? ______________
Any chronic or severe back pain? ______________________________

SKIN: Any skin lesions that are changing, growing, or need attention? ______________________________

SLEEP: Are you sleeping well? ______________________ Number of hours per night: ________________

PSYCHOLOGIC: Is stress level high, low, or average? ________________ Any feelings of anxiety, depression, or nervousness? ______________________________

NEUROLOGIC: Any chronic or unusual headaches? ________________ Any numbness or tingling? __________
Any light-headedness, dizziness, or fainting spells? ______________________________

Signed by: ______________________________ **Date**: ______________________

REVIEWED ON ____________________, **BY** ______________________________, **M.D.**

WISEMAN FAMILY PRACTICE

Integrative Medicine and Total Wellness

Authorization for Release of Medical Information

Patient Name: ____________________________________ **Date of Birth:** ___________

Best Contact Number: ____________________

Records Release ☐ **From** ☐ **To** ☐ **STAT**

Wiseman Family Practice

2500 South Lakeline Blvd Suite 100

Cedar Park, TX 78613-2968

Phone #: (512) 345-8970 Fax #: (512) 345-6689

Records Release ☐ **From** ☐ **To** ☐ **STAT**

Name of Organization/Individual: ____

Street Address: ____

City, State, Zip Code: ____

Phone #: ______________________________ Fax #: ___________________________

Please Check the Following:

☐	History/Physical Exam	☐	Laboratory Reports
☐	Progress Note/Office Reports	☐	Imaging Reports/EKG
☐	Immunizations	☐	Other: ________________

Reason you are requesting and/or transferring your record(s): _______________________

Signature of Patient: ______________________________ Date: __________________

Signature of Parent/Responsible Party: ____

Relationship to Patient: ________________________

Prohibition on Disclosure: *This information is being disclosed to you from confidential records. Their confidentiality is protected by law. You are prohibited from making any further disclosure on the information except with the specific written consent of the person to whom it pertains and the facility from with the information originates*