BROWDER CLINIC

7005 WOODWAY DRIVE, SUITE 201, WACO, TEXAS 76712-6162 254.732.3633

Patient Information

Date _____

*Name*_____
Last *First* *Middle*

Name by which you would like to be addressed in the office _____

Address _____ *City* _____ *State* _____ *Zip* _____

Home Phone _____ *Work Phone* _____ *Cell Phone* _____

Email Address _____ *Driver's License Number* _____

Date of Birth _____ *Age* _____ *Social Security Number* _____

Marital Status Single ____ *Married* ____ *Divorced* ____ *Widowed* ____ *Sex Male* ____ *Female* ____

Employer Name _____ *Position* _____

Spouse's Name _____ *Spouse's Phone* _____

Have you or any family member previously been seen in our office? _____ *If yes, who?* _____

Who referred you to our office? _____

Local Pharmacy _____ *Phone* _____

Mail Order Pharmacy _____ *Phone* _____ *Fax* _____

Major Medical Insurance or Medicare Coverage *(for care rendered outside our office)*

Primary Insurance _____ *Policy #* _____ *Group #* _____

Secondary Insurance _____ *Policy #* _____ *Group #* _____

Policy Holder Name _____ *Policy Holder S.S.#* _____

Policy Holder Date of Birth _____ *Relationship to Patient Self* ____ *Spouse* ____ *Parent* ____

Policy Holder Employer's Name _____*Phone* _____

Emergency Contact

Name _____ *Relationship* _____

Cell Phone _____ *Work Phone* _____ *Home Phone* _____

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Response Form

Name _____ *Date of Birth* _____

Cell Phone _____ *Email*_____

Address _____ *City* _____ *Zip* _____

Please Enroll me as a new patient of Browder Clinic

____ *I have enclosed a check for my initial annual fee. Please debit this account to pay the annual fee each year at time of annual contract renewal.*

____ *Please debit my checking account for my initial annual fee. Please debit this account to pay the annual fee each year at the time of annual contract renewal. (Please enclose a voided check.)*

____*Please debit my checking account for the monthly fees every month. (Please enclose a voided check.)*

____*Please charge my debit card account for the total annual fees.*

____*Please charge my credit card account for the total annual fees.*

____*Please charge my debit card account for the monthly fees every month.*

____*Please charge my credit card account for the monthly fees every month.*

Patient Signature _____ *Date* _____

____ *Debit Card Information* ____ *Credit Card Information*

____ *MasterCard* ____ *Visa* ____ *American Express* ____ *Discover*

Card Number _____ *Expiration Date* _____

Name on Card _____ *Total Payment* _____

Billing Address _____ *City* _____ *Zip* _____

Card Holder Signature _____ *Date* _____

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New Patient Health Information

Name _____ *Age* _____ *Date* _____
Current Medical Problems _____
_____
Past Medical History _____
_____
Past Surgical History _____
Family History _____
Current Medications _____
_____
Exercise _____ *Tobacco* _____ *Alcohol* _____ *Drug Allergies* _____

Please Check If You Currently Have Any of the Following Conditions

General
___*Fatigue*
___*Fever*
___*Unexplained Weight Loss*
___*Anemia*

Lung
___*Cough*
___*Shortness of Breath*
___*Wheezing*
___*Snoring/Sleep Apnea*

Gynecological
___*Pelvic Pain*
___*Abnormal Bleeding*
___*Vaginal Discharge*
___*Hot Flashes*

Urological
___*Painful Urination*
___*Loss of Control of Urine*
___*Frequent Night Urination*
___*Slow Urinary Stream*
___*Overactive Bladder*
___*Kidney Stones*
___*Prostate Problems*
___*Erectile Dysfunction*
___*Blood in Urine*

Eye
___*Eye Pain*
___ *Vision Changes*
___*Glaucoma*
___*Cataracts*

Heart
___*Chest Pain*
___*Irregular Heart Beat*
___*Rapid Heart Beat*
___*Swelling of Legs*

Breast
___*Pain*
___*Lump*
___*Discharge*
___*Cysts*

Psychological
___*Depression*
___*Stress*
___*Anxiety*
___*Loss of Interest*
___*Poor Concentration*
___*Mood Changes*
___*Insomnia*
___*Sadness*
___*Panic Attacks*

Ear/Nose/Throat
___*Chronic Nasal Pain*
___*Ear Pain*
___*Nose Bleed*
___*Hearing Loss*

Gastrointestinal
___*Abdominal Pain*
___*Nausea/Vomiting*
___*Abnormal Bowel Movement*
___*Difficulty Swallowing*

Joints
___*Arthritis*
___*Chronic Back Pain*
___*Muscle Pain*
___*Leg Cramps*

Neurological
___*Chronic Headaches*
___*Dizziness*
___*Numbness*

Skin
___*Recent Change in a Mole*
___*Rash*
___*Itching*
___*Abnormal Lump or Gland*

BROWDER  *CLINIC*

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Health Insurance Portability And Accountability Act (HIPAA)

I hereby authorize Browder Clinic to release medical information regarding my care and treatment as provided by this authorization. I understand that this Authorization applies to all records created in the course of my treatment, including information regarding my medical condition and treatment, mental health, alcohol/drug abuse diagnosis and treatment, and communicable disease status including AIDS/HIV.

_____ _____
Patient Name *Dates of Treatment*

_____ _____ _____
Social Security Number *Date of Birth* *Cell Phone Number*

Information to be Used and/or Disclosed

___ *All Healthcare Information*

___ *Other* _____

Persons to Whom Disclosure May Be Made
The specific persons to whom a disclosure of my Protected Health Information may be made

_____

_____

In consideration of the release of information by Browder Clinic in accordance with this request, I hereby release Browder Clinic, its agents, servants, and employees from any and all claims, demands, or liability of any kind which might arise out of the release of such information and the effects thereof. I understand that any information disclosed pursuant to this Authorization is subject to redisclosure by the recipient and may no longer be protected by law. This Authorization is subject to revocation at any time in the form of written notice from me, except to the extent that Browder Clinic has already taken action in reliance thereon. A photocopy or facsimile is valid as the original.

_____ _____
Patient or Legally Authorized Representative Signature *Date of Signature*

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Authorization To Release Healthcare Information

_____ _____
Patient Name *Date of Birth*

_____
Social Security Number

I request and authorize _____ *to release healthcare information of the patient named above to*

BROWDER CLINIC
7005 WOODWAY DRIVE
SUITE 201
WACO, TEXAS 76712-6162

This request and authorization applies to:

X All healthcare information

X Healthcare information relating to the following treatment, condition, or dates _____

_____

X I authorize the release of any records relating to HIV/AIDS, STD, alcohol, or mental health treatment.

___ *Other:* _____

X Purpose is for Continuation of Care.

X I am not required to sign this authorization in order to obtain treatment at Browder Clinic.

X If the recipient of this information is not covered under federal or state privacy law, the information may be subject to redisclosure by the recipient.

X I may revoke this authorization in writing at any time except to the extent that Browder Clinic has already relied on this authorization. To revoke my authorization, I will provide a written request to Browder Clinic.

_____ _____
Patient or Legally Authorized Representative Signature *Date of Signature*