

New Patient Registration

Please print clearly and bring this form to your first visit.

Patient information

Name (first, middle, last)	Date of birth (MM/DD/YYYY)	Age
Street address	City	State ZIP
Email	Preferred language	SSN (optional)
Reason for visit		

Interpreter needed? ☐ Yes ☐ NoSex assigned at birth ☐ Male ☐ Female ☐ Intersex ☐ Decline to answerGender identity ☐ Male ☐ Female ☐ Transgender (FTM) ☐ Transgender (MTF) ☐ Non-binary ☐ Decline to answer
☐ Other _____Sexual orientation ☐ Lesbian / gay ☐ Straight / heterosexual ☐ Bisexual ☐ Decline to answer ☐ Other _____Marital status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Decline to answerRace ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ White ☐ Decline to answer ☐ Other _____Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answerHow did you hear about us? ☐ Friend / family ☐ Internet ☐ Drive by ☐ Mailer ☐ Social media
☐ Other _____**Contact information**

Main phone	Alternate phone
Previous primary care physician	Their phone

Emergency contact

Full name	Relationship
Phone number	Alternate phone

Pharmacy information

Pharmacy name	Phone number
Pharmacy address / location	

Insurance information

Primary insurance company

Member ID

Group no.

Policy holder name

Relationship to patient

Secondary insurance

Member ID

Release of information

List the people we may discuss your medical information with, or check the box below.

Name

Relationship

Name

Relationship

Name

Relationship

☐ **Check here only if** you do **not** authorize discussion of your medical information with anyone other than the medical professionals involved in your care. This includes lab results, radiology reports, physician notes, and prescription information.

By signing below, I give Tejas Clinic permission to discuss my medical information with the individuals listed above. If you checked the box above, please also sign below.

Printed name

Signature

Date

Consent for communication

Telephone and email. I authorize Tejas Clinic to contact me by telephone and email at the number(s) and address I have provided about my appointments, test results, billing and account matters, and coordination of my care. A phone number is required so the practice can reach me about my care.

Text messaging. Text messaging is a separate, optional service. If you would like to receive text messages from us, complete the SMS consent section below. You do not have to agree to texting to become or remain a patient.

Text messaging (SMS) consent — optional

This consent is optional. It is not a condition of treatment, of purchase, or of receiving any service. Leaving the box below unchecked will not affect your care in any way. You may withdraw this consent at any time.

Mobile number (required for texting)

Mobile carrier

☐ I agree to receive text messages from Tejas Clinic, including appointment, account, and marketing messages. Msg frequency varies. Msg & data rates may apply. Reply STOP to opt out, HELP for help.

Your mobile information will not be sold or shared with third parties for promotional or marketing purposes. Our full Privacy Policy and Terms of Service are available at tejasclinic.com/privacy and tejasclinic.com/terms.

By signing below and providing my mobile number, I agree to receive SMS appointment reminders, account and billing notifications, care and health-related updates, and marketing and promotional messages from Primary Care Clinics US PLLC d/b/a Tejas Clinic. Message frequency may vary. Standard message and data rates may apply. Reply STOP to opt out. Reply HELP for help. Consent is not a condition of purchase or of treatment.

Printed name

Signature

Date

Notice of privacy practices

- ☐ I acknowledge that I have been offered and given the opportunity to review a copy of the Notice of Privacy Practices of Primary Care Clinics US PLLC d/b/a Tejas Clinic, which describes how my protected health information may be used and disclosed.

Notice of electronic disclosure (Texas Health & Safety Code § 181.154). Because Primary Care Clinics US PLLC d/b/a Tejas Clinic creates, stores, and electronically transmits medical and billing records, we are required to notify you that your protected health information is subject to electronic disclosure. Texas and federal law prohibit electronic disclosure of your protected health information to any person without a separate authorization for each disclosure, except for disclosures made for treatment, payment, or health care operations, or as otherwise authorized or required by state or federal law.

Legal information and policies

As a patient of Tejas Clinic, I understand that the following policies are currently in effect:

Consent for treatment. I voluntarily consent to and authorize Tejas Clinic healthcare providers to provide healthcare services to me. These services may include, without limitation, routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and medical treatment; routine laboratory procedures and tests; x-rays and other imaging studies; administration of medications; and procedures and treatments prescribed by the clinic's healthcare providers.

Assignment of benefits. I authorize my insurance benefits to be paid directly to Tejas Clinic and its related companies. I understand that I am financially responsible for any balance my insurance does not cover. I also authorize Tejas Clinic, its related companies, or my insurance company to release medical information required for claims. I understand I am responsible for knowing what my insurance plan does and does not cover.

Prolonged care. In accordance with AMA CPT guidelines, we reserve the right to bill for telephone calls with our medical professionals that include evaluation and management of your medical condition, as well as time spent on extensive medical review or coordination of care.

Payments. Payment is due at the time of service, including copays, deductibles, coinsurance, and any prior balance. This arrangement is part of your contract with your insurance company, and failure on our part to collect these amounts can be considered fraudulent. Please help us uphold the law by paying your patient responsibility at each visit. A card on file is required. We accept Visa, Mastercard, American Express, cash, and checks. I understand I am responsible for all charges for services rendered to me or my dependents. If you have questions about your coverage, please call your insurance company. If you are unable to pay for your visit, you will need to reschedule until you are able to cover the visit cost.

Deductible-based plans. A deductible is the amount you must pay out of pocket before your insurance pays. Tejas Clinic collects an estimated cost for all services rendered in the office. Any remaining balance will be reflected after the claim is processed and billed to you. If you overpay, we will refund you once we receive payment from your insurance.

Card on file. A card on file is **required** for all patients. It keeps check-in quick and reduces collection efforts, which lets our office focus more on patient care.

Non-payment. Statements are sent regularly for all past-due accounts. If payment is not made, we will make one phone call to arrange payment. If no resolution can be reached, the account will be sent to our collection agency and may result in discharge from the practice. If this occurs, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician can treat you on an emergency basis only.

Termination. Patients who do not follow treatment plans, follow-ups, or office policies, or who are violent or verbally abusive toward providers or staff, may be discharged from the practice.

Annual / physical exams. This type of visit is **preventive only**. If you want other health issues addressed during your annual or physical exam, we will bill your insurance for both a sick visit and a well visit. Your insurance may not pay for the combined visit, in which case you are responsible for the full balance. To avoid this, you may reschedule the annual or physical exam for another day.

Laboratory services. Laboratory billing is separate from the physician bill you receive. We are not responsible for laboratory billing issues that arise after the service is provided. We may recommend labs as part of your annual checkup or for your medical conditions, but we cannot guarantee insurance coverage for them.

Labs & imaging. All lab results are reported to patients within 7 days. Your provider **must see you** within 1–2 weeks, or sooner, for all abnormal lab and imaging results so we can help with management and your treatment plan.

Prescriptions. Your provider **must see you** before prescribing a new medication, refilling antibiotics or controlled medications (narcotics), or changing an existing medication. No controlled medication will be prescribed over the phone, out of state, after hours, or on weekends. If you have not been seen by your provider within the past 3 months and need a refill, you must schedule an appointment. All medications follow an appointment refill schedule to keep our patients safe; please ask our staff if you have questions about it.

Referrals. Obtaining a referral from your insurance can take 72 hours or more. Please do not call from the specialist's office at the time of your appointment to request a referral. An appointment is required to obtain a referral.

Medical records. There is a \$35 fee for printing medical records for the first 20 pages, and 50 cents for each page thereafter. For electronic records, the fee is \$25 for 500 pages or fewer and \$50 for more than 500 pages. When you request a copy of your own records under the HIPAA individual right of access, any fee charged will be limited to a reasonable, cost-based fee as required by 45 C.F.R. § 164.524(c)(4).

No-shows. If you do not show up, or do not call us at least 24 hours in advance to cancel or reschedule your appointment, we reserve the right to charge a \$25 fee for the time we were unable to offer to other patients. After three consecutive no-shows or reschedules, we reserve the right to discharge you from the practice.

Disability / FMLA. An appointment is **required** for all requests. There is a \$35 fee for completing FMLA or disability documents.

Acknowledgment

By signing below, I certify that I have read and understand the legal information and policies listed above, and I consent to treatment at Primary Care Clinics US PLLC d/b/a Tejas Clinic.

Printed name

Signature

Date

Medical History

Patient name

Date of birth

Personal medical history

Check all that apply to you.

- | | | |
|--|--|---|
| ☐ ADHD / ADD | ☐ Anemia | ☐ Anxiety |
| ☐ Arthritis | ☐ Asthma | ☐ Atrial fibrillation |
| ☐ Blood clot in vein | ☐ Cancer | ☐ Chest pain |
| ☐ Chronic pain | ☐ Congenital disease | ☐ COPD |
| ☐ Coronary artery disease | ☐ Depression | ☐ Diabetes |
| ☐ Dizziness | ☐ Heart disease | ☐ Heart murmur |
| ☐ Hepatitis | ☐ High blood pressure | ☐ High cholesterol |
| ☐ Insomnia | ☐ Kidney problems | ☐ Liver disease |
| ☐ Migraine | ☐ Mood disorders | ☐ Osteoporosis / osteopenia |
| ☐ Palpitations | ☐ Peripheral arterial disease | ☐ Pneumonia |
| ☐ Rheumatological disease | ☐ Seizures | ☐ Sexually transmitted infection (STI) |
| ☐ Shortness of breath at rest | ☐ Shortness of breath on exertion | ☐ Sleep apnea |
| ☐ Stroke | ☐ Thyroid disorder | |

If cancer, what kind?

Additional history / notes

Describe any other conditions, ongoing symptoms, or concerns you would like your provider to know about.

Surgical procedures / hospitalizations

Surgical procedure / hospitalization	Month / year

- ☐ I have had no surgical procedures ☐ I have had no hospitalizations

Family history

Do any of the following conditions run in your family? If so, list the relationship.

Mother's age

Father's age

Condition	Relationship	Alive?
☐ Stroke		
☐ Heart attack / heart disease		
☐ High cholesterol		
☐ High blood pressure		
☐ Thyroid disorder		
☐ Cancer (type: _____)		
☐ Diabetes		
☐ Genetic condition		
☐ Breast disease		

☐ My family has no known health conditions

Social history

Do you smoke? ☐ Yes ☐ No ☐ Former smoker

If yes, how many per day?

If former, when did you stop?

Do you use any other tobacco or nicotine products? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

If yes, how many drinks per week?

How often do you have 6 or more drinks on one occasion?

Have you used recreational or illegal drugs? ☐ Yes ☐ No

If yes, which ones?

Occupation

Exercise (days per week)

Preventive screening history

What year, if ever, did you last have the following?

Routine bloodwork	Flu vaccine	COVID-19 vaccine	Pneumonia vaccine (50+)
Shingles vaccine (50+)	Pap smear (women 21+)	Mammogram (women 40+)	Last menstrual period
Colonoscopy / Cologuard (45+)	Prostate screening (men 50+)	Bone density screening (65+)	Last fall (65+)
Vasectomy (men)	Hysterectomy (women)	Diabetic eye exam	Dental exam

Medication list

List all medications you currently take, including over-the-counter drugs, vitamins, herbal products, and supplements.

Name of medication	Dose / strength	How often (frequency)

☐ I am not currently taking any medications

Allergies

List all known food, drug, and environmental allergies and the reaction each one causes.

Food / drug / substance	Reaction	Severity (mild / moderate / severe)

☐ I do not have any known allergies

Office use only

Reviewed by

Date

Chart #