THE BRADLEY CLINIC
REGISTRATION FORM

(Please Print)

Today's date: PCP:

PATIENT INFORMATION

Last name: First: MI: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No If not, what is your legal name? (Former name): Birth date: / / Age: Sex: ☐ M ☐ F

Street address: Social Security no.: Home phone no.: ( )

P.O. box: City: State: ZIP Code:

Occupation: Employer: Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ☐ Dr. ☐ Insurance Plan ☐ Hospital ☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

Other family members seen here:

FEMALES ONLY: Are you Pregnant? ☐YES ☐NO

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: Birth date: / / Address (if different): Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation: Employer: Employer address: Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance ☐ Blue Cross Blue Shield ☐ Aetna ☐ Medicare*** ☐ Cigna ☐ TriCare ☐ United Healthcare ☐ Mutual of Omaha ☐ Humana ☐ Health First-Tyler ☐ Other

Subscriber's name: Subscriber's S.S. no.: Birth date: / / Group no.: Policy no.: Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable): Subscriber's name: Group no.: Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): Relationship to patient: Home phone no.: ( ) Work phone no.: ( )

I hereby give authorization for payment of insurance benefits to be made directly to The Bradley Clinic 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 information necessary to secure the payment of benefits.
I further agree that a photocopy of this agreement shall be as valid as the original.

Patient/Guardian signature *Date*

ILLNESS/INJURY: Please check if you have ever had any of the following

Yes	No		Yes	No	
		High blood pressure			Kidney stones
		Diabetes			Abdominal bleeding
		Peptic ulcers			Diverticulosis
		Heart attack			Thyroid problem
		Chest pain/tightness			Lung problems/asthma
		History of heart murmur			Shortness of breath
		Stroke			Seizures
		Cancer			Depression
		Hepatitis			High Cholesterol
		Yellow jaundice			Arthritis
		Gallstones			Cataracts

Surgeries (including childbirth)

Year	Name of operation	Type of anesthetic, if known	Complications

MEDICATIONS: Please list all medications you take and their dosages ***(continue on reverse side if necessary***

Drug	*Dosage*	*Drug*	*Dosage*

Have you ever had a blood transfusion? ( ) No Yes ( ) If yes,

when_____

Please list medical conditions not listed above:

_____

_____

_____

ALLERGIES: Please list type and reaction ☐ No known allergies

Drug	Reaction

Marital status:

□Single □Married (how long? ___) □Separated □Divorced (how long? ___) □Widowed (how long? ___)

Number of others in home_____

History

Significant birth events:

Premature birth? □ Yes □ No

List all injuries (continue on the reverse side if necessary):
Injuries Date(s)

List any other medical conditions you have had (do not include common cold or flu):
Illnesses Date(s)

How often do you get a cold?

_____

If your family has a history of any of these conditions, please do the following:

a. Circle the condition

b. Write 'F' for father, 'M' for mother, or 'S' for sibling within the parentheses

Heart disease		Cancer		Alcoholism	
Kidney problems		Depression		Migraines	
Stroke		Schizophrenia		Other	
High blood pressure		Early senility		Obesity	
Diabetes		Manic-depressive disorder		Seizure disorder	

Father ( ) Alive Age____ ( ) Deceased at age_____ Cause of death:

_____

Mother ( ) Alive Age____ ( ) Deceased at age_____ Cause of death:

_____

Initials_____

List all supplements/alternative remedies (vitamins, minerals, herbs, etc.) you are currently taking and/or alternative

Treatments you are undergoing (continue on reverse if necessary):

Supplement/Alternative treatment Size (mg, mcg, etc.) Daily dose

_____

_____

List any handicaps or impairments (such as vision or hearing loss):

Review of systems

Are you currently experiencing any of these symptoms?

Yes	No	1. Constitutional
		Recent fever
		Recent weight loss
		Fatigue
		2. Eyes
		Glaucoma
		Recent changes in vision
		3. Ears, Nose, Mouth, Throat
		Frequent ear infections
		Ringing in the ears
		Earaches or drainage
		Frequent sore throats
		Frequent sinus infections
		Nose bleeds

		4. Cardiovascular
		Sudden heartbeat changes
		Swelling of feet, ankles, hands
		Chest pains or discomfort in chest
		5. Respiratory
		Frequent coughing
		Spitting up blood
		Wheezing
		Asthma, bronchitis, pneumonia, pleurisy, TB
		6. Gastrointestinal
		Frequent indigestion or heartburn
		Vomiting
		Passing bloody or black stools
		Stomach pain
		Loss of appetite
		7. Genito-Urinary
		Blood in urine
		Painful/burning urination
		8. Musculoskeletal
		Frequent fractures or sprains
		History of arthritis
		9. Skin
		Recent changes in skin
		Rash or itching
		Change in hair or nails
		10. Neurological
		History of frequent headaches
		Numbness or tingling sensation
		Seizures or convulsions
		Tremors
		Paralysis
		11. Psychiatric
		Treatment for psychiatric problems
		Treatment for drug or alcohol dependency

		Sleep problems
		Memory loss or confusion
		Nervousness / Depression
		12. Endocrine
		Decreased energy
		Dizziness
		13. Hematologic / Lymphatic
		Easy bruising or bleeding
		Swollen glands
		Slow to heal after cuts
		14. Allergic / Immunologic
		Severe allergic reactions to:
		Hay fever

Social history

Yes	No	
		Do you smoke now? ___ Cigarettes ___ Cigars __ Pipe. How many per day?
		Have you smoked in the past? (year quit: __)
		Do you drink alcohol now? If yes how much per day?
		Did you drink alcohol in the past?
		Do you currently use street drugs?
		Have you used street drugs in the past?

Signature of person completing the form:

□ Patient □ Other _____ Date _____

THE BRADLEY CLINIC at Tyler

HIPAA

I understand that I can grant/restrict access to my Private Health Information at The Bradley Clinic at Tyler. My health information is used/disclosed to carry out treatment, payment or procedures. My health information will not be used or disclosed for marketing and fundraising purposes. My health information is also prohibited from being sold without my authorization.

I understand that, upon my written request, I have the right to receive electronic copies of my health information and restrict disclosures to a health plan concerning treatment for which I have paid out of pocket in full.

I understand that I am to be notified if there is a breach with my health information.

I understand that if I were to die, my health information can be disclosed to family members or others who were involved in my care prior to death, unless any prior expressed preference made by me, that is known to The Bradley Clinic.

I have been given the opportunity to review The Bradley Clinic policy outlining the requirements for granting access/restriction of health information. I understand that The Bradley Clinic reserves the right to deny this request dependent upon individual circumstances.

I request that the following person(s) have access to my Private Health Information as indicated by check below:

NAME	INFORMATION RELEASE PREFERENCE		
	Clinical ALL	Clinical *Restricted	Financial
	Clinical ALL	Clinical *Restricted	Financial
	Clinical ALL	Clinical *Restricted	Financial
	Clinical ALL	Clinical *Restricted	Financial

* Restricted - Please indicate what information you DO NOT wish to share by checking the appropriate box(s):

- Sexually Transmitted Disease
- Pregnancy
- Terminal Illness
- Mental/Behavioral
- Other: _____

Preferred means of contact:

- ☐ Home/Answering machine
- ☐ Work
- ☐ Cell/Voice Mail

_____ _____ _____

Patient Signature Date Witness Signature

Verbal requests require unique identification, i.e., the last four of patient's social security number.

THE BRADLEY CLINIC
at Tyler

Dr. Dale Bradley, D.O.

MEDICAL RECORDS RELEASE FORM

This form authorizes you to provide a copy, summary, or narrative of your medical records (as indicated by check mark (s) below), or otherwise release confidential information.

Patient Name:
Address:

Patient DOB: _____ SS# _____

Records Requested:
- ☐ Complete Record
- ☐ Records of care from the following dates: _____ to _____
- ☐ Lab Results
- ☐ Other- Please Specify: _____

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS of infection with any other causative agent of AIDS with the rest of my medical records.

Patient's Initials: ____ Date: _____

Release FROM the following person(s):

Name: _____

Address: _____

Phone: _____

Fax: _____

Release TO the following person(s):

Name: _____

Address: _____

Phone: _____

Fax: _____

Reason for release of records: _____

NOTICE TO RECIPIENTS OF INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42. CFR part 2) prohibit you or your organization from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulation. A general authorization or the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client/patient.
MENTAL HEALTH: This information is released subject to the "Confidentiality" provisions of TX.H.S. Code 611 and Texas Rules of Evidence (Civil/Criminal) Rules 510.
DRUG/ALCOHOL: This information is released subject to the "Confidentiality" provisions of 42 U.S. C 290dd-2; 42 C.F.R > Part 2.
MR. This information is released subject to "confidentiality" provisions of the Mentally Retarded Person Act of 1977, and TX: U.S. Code CH 595.
HIV/AIDS: This information is released subject to "Confidentiality" provisions of the Communicable Disease Prevention Control Act of 1987, and as amended TX.H.S. Code 81.001; the Human Immunodeficiency Virus Services Act, TX.H.S. Code 85.001.

Patient Signature: _____ Date: _____

THE BRADLEY CLINIC

Dale J. Bradley, D.O.
www.thebradleyclinic.com

1402 Rice Road, Suite 100, Tyler, Texas 75703 ✣ Phone: (903)630-7691 ✣ Fax: (903)630-7693

NARCOTIC MEDICATION AGREEMENT

You have agreed to receive narcotics for the treatment of your pain. It is important that you have an understanding of the risks and responsibilities that go along with this treatment. Please **read each statement and sign** this agreement/contract below. If you have any questions regarding this information or the office policy regarding the prescribing of narcotics, please request clarification.

I, _____, understand that:

Any medical treatment is initially a trial, and that continued prescription is based on evidence of benefit. I understand that the goal of using narcotics is to decrease my pain and increase my functional level. If my pain does not significantly decrease and/or my function increase, the medication will be stopped.

I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, lightheadedness, dizziness, confusion, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, kidney or liver disease, sexual dysfunction, physical dependence, tolerance to analgesia, addiction, withdrawal and the possibility that the medicine will not provide complete relief. The overuse of narcotic medication can result in serious health risks including respiratory depression or even death.

This medication will be strictly monitored and all of my medications should be filled at the same pharmacy. (Should the need arise to change pharmacies our office **must** be informed). The pharmacy that I have selected is:

Pharmacy: _____
Phone: _____

I **cannot** receive this medication by phone. I will not call the office to have a prescription called in.

I am responsible for making and keeping scheduled appointments. Early refill requests will not be honored.

I will take the narcotic medication **only as prescribed.** Any changes **must** first be discussed and agreed upon with The Bradley Clinic.

Medications **will not** be replaced if they are lost, get wet, are destroyed, left on an airplane, etc.

I agree that only The Bradley Clinic will prescribe my narcotic medication. I will not obtain or use narcotics or other controlled substances from a source other than The Bradley Clinic. I will instruct my other physicians to confer with The Bradley Clinic for any changes or need for

additional narcotic medications. If it is brought to the attention of the clinic that other providers are prescribing medications for me, The Bradley Clinic reserves the right to discontinue prescribing medications and/or discharge me from the clinic.
I have been given a copy of The Bradley Clinic – Long Term Opiod Analgesic Medication Information packet and understand that I may ask the physician and/or pharmacist questions about my medication and treatment.

I will inform the Bradley Clinic of any changes in my medical condition, any changes in any prescription and/or over the counter medication that I take and of any adverse effects that I may experience from any of the medications that I take.

I agree to tell my physician my complete and honest personal drug / medication usage and history.

I will not use any illegal "street drugs" while receiving medications from The Bradley Clinic.

I will communicate fully and honestly with my physician about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

Routine blood work and random drug screens may be a part of my treatment plan. I agree to have them done on the day the physician requests it.

The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for purposes of maintaining accountability.

If the responsible legal authorities have questions concerning my treatment, as might occur, for example, if I were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to my records.

It is a felony to obtain narcotic medications under false pretenses. This could include getting medication from more than one doctor, misrepresenting myself to obtain medications, using them in a manner other than prescribed or diverting the medications in any other way (selling).
I know that narcotic medications will be stopped if any of the following occurs:

- I trade, sell, or misuse the medication
- The clinic finds that I have broken any part of this agreement
- I do not go for a blood or urine test when asked
- My blood or urine test shows the presence of medication that the staff are not aware of, the presence of illegal drugs, or does not show medications that I am receiving a prescription for
- I get narcotics from sources other than The Bradley Clinic
- Any member of the professional staff of The Bradley Clinic feels that it is in my best interests that narcotic treatment is stopped
- Any aggressive behavior toward physician or staff

- I consistently miss scheduled appointments

It is understood that failure to adhere to this agreement may result in cessation of therapy with controlled substance prescribing (no narcotic prescriptions will be written) by The Bradley Clinic physicians.

I have read the Narcotic Medication Agreement and without question understand all of this agreement. By signing this agreement, I affirm that I have read, understand and accept all of the terms of this agreement.

Patient Signature: _____ Date: _____

Clinic Witness: _____ Date: _____