THE BRADLEY CLINIC at Tyler

THE BRADLEY CLINIC
REGISTRATION FORM
(PLEASE PRINT)

Date: PCP:

PATIENT INFORMATION

Mr. Mrs. Ms. Miss. LAST NAME: ______________________ FIRST NAME: _____________ MI: __

Single / Mar / Div / Sep / Wid FORMER LAST NAME: ____________________

BIRTH DATE: _______________ AGE: ______ SEX: M / F

STREET ADDRESS: ____

____

CITY: _____________ ST: ___ ZIP:_________

HOME PHONE: _________________________ CELL PHONE: ______________________________

EMPLOYER: _____________________________________ OCCUPATION: ___________________________

EMPLOYER NUMBER: (___)_______________________

INSURANCE INFORMATION

PRIMARY	SECONDARY
Ins. Co. Name:	Ins. Co. Name:
Policy Holder Name:	Policy Holder Name:
Policy Holders DOB: / /	Policy Holders DOB: / /
Group Number:	Group Number:
ID Number:	ID Number:
Verify Benefits Phone Number:	Verify Benefits Phone Number:
Patient relationship to Policy Holder:	Patient relationship to Policy Holder:

EMERGENCY CONTACT

Name: ____ Relationship:_____________________________

Phone number: (___)_________________

Patient/Guardian Signature: ____________________________________ Date: ______________________

Initials: __________

MEDICAL HISTORY:

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

SURGICAL HISTORY (including child birth):

YEAR	Name of operation	Type of anesthetic, if known	Complications

MEDICATIONS: Please list any medications you take and their dosages (continue on reverse side if necessary.)

DRUG	DOSAGE	DRUG	DOSAGE

Initials: __________

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

____
____
____
____

Please list any current treatments you are undergoing.

____
____
____
____
____

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

When?____

How often do you get colds? ____

ALLERGIES: Please list type and reaction. No know allergies ( ).

DRUG	REACTION

HISTORY:

List all injuries and dates (continue on the reverse side if necessary):

____
____
____
____
____

List any handicaps:

____

Initials: __________

FAMILY HISTORY:

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 next to the condition.

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

Father alive ( ) age ____ Deceased at age ____ Cause of death: ________________________________.

Mother alive ( ) age ____ Deceased at age ____ Cause of death: ________________________________.

REVIEW OF SYSTEMS

YES	NO	1. CONSTITUTIONAL	YES	NO	5. RESPIRATORY
		Recent fevers			Frequent coughing
		Recent weight loss			Spitting up blood
		Fatigue			Wheezing
		2. Eyes			Asthma, bronchitis, pneumonia
		Glaucoma			Pleurisy, TB
		Recent changes in vision			6. GASTROINTESTINAL
		3. EARS, NOSE, MOUTH, THROAT			Frequent indigestion or heartburn
		Frequent ear infections			Vomiting
		Ringing in the ear			Passing bloody or black stools
		Ear aches or drainage			Stomach pains
		Frequent sore throats			Loss of appetite
		Frequent sinus infections			7. Genito-Urinary
		Nose bleeds			Blood in urine
		4. CARDIOVASCULAR			Painful/burning urination
		Sudden heartbeat changes			8. MUSCULOSKELETAL
		Swelling of the feet, ankles or hands			Frequent fractures or sprains
		Chest pains or discomfort in chest			History of arthritis

Initials: __________

YES	NO	9. SKIN	YES	NO	Sleep problems
		Recent changes in skin			Memory loss or confusion
		Rash or itching			Nervousness/ depression
		Change in hair or nails			12. ENDOCRINE
		10. NEUROLOGICAL			Decreased energy
		History of frequent headaches			Dizziness
		Numbness or tingling sensation			13. HEMATOLOGIC/LYMPHATIC
		Seizures or convulsions			Easy bruising or bleeding
		Tremors			Swollen glands
		Paralysis			Slow to heal after cuts
		11. PSYCHIATRIC			14. ALLERGIC/IMMUNOLOGIC
		Treatment for psychiatric problems			Severe allergic reactions to:
		Treatment for drug/alcohol dependency			Hay fever

SOCIAL HISTORY:

YES	NO	
		Do you smoke now? ____ Cigarettes ___ Cigars___ Pipe___. How many per day?_____
		Have you ever 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 ever used street drugs in the past? ______

Signature of person completing the form: Relationships to patient ____________________________

____ DATE___________________________

Initials: __________

CANCELLATION POLICY

Dear Patient,

We strive to provide the best medical care for you, your family, and all of our patients. In order to do so effectively, we have an appointment system that sets ample time for each patient.

"No-shows", and late cancellations inconvenience others who need access to medical care in a timely manner. In an effort to reduce the number of occurrences, we have implemented this Cancellation Policy, and it is effective immediately.

The policy is as follow:

1. We request that you give our office a **24-hour** notice if you need to reschedule your appointment. Our office number is 903-630-7691.
2. If you miss an appointment and do not contact us with an appropriate reason for cancelling, this will be considered a no-show appointment and it will result in a **$35.00 no show fee** to be assessed to you.
3. If you are late for your appointment without prior notification to our office, you may be rescheduled to a later date. Please notify our office if you are late, so that we may continue to accommodate other patients.

If you **NO SHOW** three appointments, you could be dismissed as a patient!

This fee will be billed to you directly and it is not covered by insurance. This balance must be paid prior to your next appointment. If you do not have a scheduled appointment, the balance is expected in a timely fashion and if not, it will be subjected to collections.

We thank you for choosing and trusting The Bradley Clinic at Tyler with your care.

I have read and understand the Cancellation Policy and agree to the terms of this policy.

_________________________________ _________________________________

Signature DATE

____

Printed Name

Initials: __________

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

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

INFORMATION RELEASE PREFERENCE

NAME: (Circle)

	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: Phone/Answering machine
Work
Cell/voicemail
Email

____

Patient Signature Date

**verbal request require unique identification, i.e., the last four of patients social security number.

Initials: __________

MEDICAL RECORDS RELEASE FORM

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

Patients Name: ____________________________
Address: __________________________________
____
Patients DOB: ________________ SS#__________________

Records Requested:
___ Complete records
___ 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 agents of AIDS with the rest of my medical records.

Patients initials: ______ Date: _______________

Release FROM the following person(s):	Release TO the following person(s):
Name:____________________________	Name: _________________________________
Address: __________________________	Address:________________________________
__________________________________	____
Phone: ____________________________	Phone: _________________________________
Fax: ______________________________	Fax: ___________________________________

Reason for release of records:____

Patients Signature: ____ Date: _________________________

Initials: __________

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 medication treatment is initially a trail, 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 risk 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 medication 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 medications. 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 medications. If it is brought to the attention of the clinic that other providers are prescribing medications for me, The

Initials: __________

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 Opioid 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 medication conditions, 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 request 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 medications 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 show 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 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 physician.

Initials: __________

I have read the Narcotic Medication Agreement 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.

Patients signature:____________________________________ Date:_________________________

Clinic Witness: _______________________________________ Date:_________________________

Initials: __________