



7692 Eldorado Parkway
 McKinney, Texas 75070
 972.562.8388 (Phone)
 972.540.2219 (Fax)

Health History Form

Full Name: _____ M ___ F ___ Date: _____

Medical Allergies _____

Disease (Check all that apply)	Self	Mom	Dad	Sis	Bro	GM	GF	Hospitalizations
Allergic Rhinitis/Hay Fever								Reason: _____ Yr: _____
Anemia								Reason: _____ Yr: _____
Arthritis								Reason: _____ Yr: _____
Asthma								Reason: _____ Yr: _____
Blood Transfusion								Reason: _____ Yr: _____
Breast Cancer								Reason: _____ Yr: _____
Cataracts								Reason: _____ Yr: _____
Colon Cancer								Reason: _____ Yr: _____
Depression								Surgeries
Anxiety								
Mental Illness								
Diabetes								
Drug/Alcohol/Physical Abuse (Circle which apply)								
Emphysema								
Lung Problems								
Endometriosis								Do you use any form of Tobacco? Yes _____ No _____
Hearing Problems								Type & Amount: _____
Heart Disease								Do you drink Alcoholic Beverages? Yes _____ No _____
Heart Attack								Amount: _____
High Blood Pressure								Treated for Substance Abuse? Yes _____ No _____
High Cholesterol								When? _____
Irritable Bowel Syndrome								Sexually Active? Yes _____ No _____
Kidney Problems								Women Only:
Migraines								
Neurological Disease								
Peptic Ulcer Disease/ GI Problems								
Positive TB Test/Tuberculosis								Age Menses Began: _____
Sexually Transmitted Disease								Regular Menses Y__ N__ LMP _____
Stroke								Last PAP _____ Last Mamm _____
Thyroid Problems								Ob/Gyn Dr. _____
Other:								Number of Pregnancies: _____
								Form of Contraception: _____
Current Medications	Dosage							Frequency
1.								
2.								
3.								
4.								

I certify that the above information is correct and true to the best of my knowledge. I will not hold my doctor or any members of the staff responsible for any errors or omissions that I may have made in the completion of this form.



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Patient Information
(Please Print)

Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Birth date: _____ Age: _____ SSN: _____ Sex: M ___ F ___

Drivers License: _____ Single: ___ Married: ___ Widowed: ___ Separated: ___ Divorced: ___

Patient Employed by: _____

Business Address: _____

In case of emergency who should be notified? (Someone not living with you)

Name: _____ Phone Number: _____

Primary Insurance

Full Name of Responsible Person: _____

Relation to Patient: _____ Birth Date: _____ SSN: _____

Address (If different from patients): _____

City: _____ State: _____ Zip: _____ Phone: _____

Person Responsible Employed by: _____

Business Address: _____ Phone: _____

Additional Insurance

Is patient covered by additional Insurance? Yes ___ No ___ Subscriber Name: _____

Relation to Patient: _____ Birth Date: _____

Address (If different from patients): _____

City: _____ State: _____ Zip: _____ Phone: _____

Subscriber Employed by: _____ Business Phone: _____

Insurance Company: _____ SSN: _____



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Patient Consent for Release of Personal Health Information (PHI)

Many of our patients allow family members such as their spouse, parents, or others to call & request test results/procedures, appointments & billing information or for prescription/sample pick up. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's written consent. If you wish to have your protected health information (PHI) released to anyone other than yourself, you must complete this form. This form will expire by written notification from you ONLY.

I, _____, give my consent to McKinney Family Medicine to release protected health information (PHI) such as; lab results, medication changes, prescriptions, samples, appointments, billing information, etc. to the following individuals in person or via telephone:

Form with three rows for Name, Relationship, and Phone # (if different from patient)

AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION BY ALTERNATE MEANS

Please check all that apply:

- May leave detailed message on voicemail at home #: _____
May leave detailed message on voicemail at work #: _____
May leave information with spouse (name): _____
May leave information with other family member (name): _____
May leave detailed message on mobile phone #: _____
Do NOT leave any detailed message on any phone.
May send email to: _____

**Please note: Detailed message includes lab/test results, medication, and/or billing information.

Signature _____ Date of Birth _____

Relationship: Self Spouse Parent/Guardian to _____ Other _____
(Patient Name & DOB)

Date _____



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Assignment and Release

With Insurance

I, _____ the undersigned certify that I (or my dependent) have insurance coverage with _____ (Insurance Company) and hereby assign/transfer and set over to McKinney Family Medicine all my rights, title and interest to my medical reimbursement benefits under my insurance policy. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that full payment (including co-payment) is expected at time of service. I hereby authorize McKinney Family Medicine to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____

Relationship _____ Date _____

Without Insurance

I, _____ the undersigned certify that I (or my dependent) do not have insurance coverage with any company. I understand that I am responsible for all charges. I understand that full payment is expected at time of service. I understand my responsibility and acknowledge it by signature on this form.

Signature of Responsible Party _____

Relationship _____ Date _____

Acknowledgement of Receipt

I, _____ have received a copy of McKinney Family Medicine's Office Policy and Notice of Privacy Practices.

Signature of Responsible Party _____

Relationship _____ Date _____

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Medical Records Release Authorization

Patient's Full Name: _____ DOB: _____
Phone #: _____ SS#: _____
Address: _____

I authorize records: (please select one):
() To be released **TO** McKinney Family Medicine from _____
Address: _____
Phone: _____ Fax: _____

() To be released **FROM** McKinney Family Medicine to _____
Address: _____
Phone: _____ Fax: _____

To release the following: _____ any and all medical records _____ operative report
_____ recent PAP results _____ recent lab results
_____ office visit for _____ other _____
(date)

The purpose of this disclosure is for **treatment/payment/healthcare operations** unless specified here:

This authorization gives McKinney Family Medicine permission to request your medical records from any health care provider that you have received treatment from as specified above for the duration that you have direct treatment relationship with McKinney Family Medicine. McKinney Family Medicine is authorized to furnish information even though the confidentiality of the information may be protected by Federal or State laws and regulations. **This includes any and alcohol and/or drug treatment records or psychiatric records and any information related to HIV or sexually transmitted disease testing or results that are in the record, unless specified above.** McKinney Family Medicine is released and discharged from any liability, and the undersigned will hold McKinney Family McKinney Family Medicine harmless for complying with this information.

- I understand the following:
- ✓ I am not required to sign this authorization.
 - ✓ I may revoke this authorization at any time by presenting my written revocation to McKinney Family Medicine, 7692 Eldorado Pkwy., McKinney, TX 75070.
 - ✓ The revocation will not apply to information that has already been used or released under this authorization.
 - ✓ Physician's office has the right under Texas State Law to require payment up front for reasonable costs of copying and mailing before furnishing the medical records.

Signature of Patient or Legal Representative

Printed Name of Patient or Legal Representative

Relationship to patient or Legal Representative

Date

Witness

Date

NOTICE TO PERSON OR AGENCY RECEIVING THIS INFORMATION: *This information has been disclosed to you from records whose confidentiality is protected. Laws and Regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient.*