Southern Horizon HEALTHCARE

2280 HIGHLAND VILLAGE RD STE 100, HIGHLAND VILLAGE TX, 75077
PH: 469-645-0200 FAX: 469-320-9550

PATIENT REGISTRATION FORM

Today's Date: _____ Referred By: _____

PATIENT INFORMATION: (Please use full legal name, no nicknames)

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Wk. #: _____

Email Address: _____

DOB: _____ Age: _____ Sex: _____ Marital Status: _____

Driver Lic #: _____ DL: State: _____ SS#: _____

*Employer Name and address: _____

Emergency Contact Name: _____ Emergency Phone: _____

GUARANTOR INFORMATION: (List person or insured name responsible for bill use full legal name, no nicknames)

Relationship of Guarantor to Patient: Self: _____ Spouse: _____ Parent: _____ Other: _____

Last name, First: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ DOB: _____ Age: _____

Employer Name & Address: _____

_____ Phone #: _____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards.)
IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE:
Plan Name: _____ *Insured's Name: _____

Insured's SS#: _____ *Insured's Date of Birth: _____

*Policy / ID#: _____ *Group #: _____ *Eff Date: _____

Claims Address & Phone: _____

SECONDARY INSURANCE:
Plan Name: _____ *Insured's Name: _____

Insured's SS#: _____ *Insured's Date of Birth: _____

*Policy / ID#: _____ *Group #: _____ *Eff Date: _____

Claims Address & Phone: _____

REQUIERED FIELDS – PLEASE COMPLETE FOR BILLING *** ATTACH COPY OF INSURANCE CARDS***

Patient Name: _____

NEW PATIENT HISTORY FORM

MAIN PROBLEMS / REASON FOR THIS CONSULTATION: (If possible rank in terms of importance to you)

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

*Note we may not be able to address every problem during one treatment.

CURRENT MEDICATIONS, VITAMINS & SUPPLEMENTS	Dose	Quantity / Times Per Day	Prescribing Doctors Name

MEDICAL HISTORY: LIST PRIOR ILLNESS, INJURIES AND OR TRAUMAS:

DATE: **DIAGNOSIS**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES: FOOD, MEDICINES, PETS **REACTION:**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Patient Name: _____

SURGICAL HISTORY:

DATE:	TYPE OF SURGERY
_____	_____
_____	_____
_____	_____
_____	_____

HOSPITALIZATION HISTORY:

DATE:	REASON FOR HOSPITALIZATION
_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY (CHECK ALL THET APPLY)

Marital Status:	**Employment Status:**
☐ Single	☐ Employed
☐ Married	☐ Un-Employed
☐ Divorced	☐ Full Time Student
☐ Widowed	☐ Retired

Living Arrangement:

☐ Alone ☐ Family ☐ Roommate ☐ Significant Other ☐ Children

☐ Major Stress in the last 2 years ☐ Money ☐ Job ☐ Marriage ☐ Home Life ☐ Children ☐ Other_____

LIFESTYLE / SELF-CARE ISSUES

Do you smoke cigarettes?	☐ Yes	☐ No	If yes, how many years? ____ How many pack per day? _____
Did you ever smoke in the past?	☐ Yes	☐ No	If yes, when did you quit? _____
Are you currently sexually active?	☐ Yes	☐ No	If yes, do you use protection? _____
Have you ever had any STD's?	☐ Yes	☐ No	If yes, please list? _____
In the past 12 months, have you used drugs? **(not for medical use)**	☐ Yes	☐ No	If yes, please list? _____
Do you smoke marijuana?	☐ Yes	☐ No	
Do you drink caffeinated beverages?	☐ Yes	☐ No	If yes, what kind, how much and how often? _____
Do you drink alcohol?	☐ Yes	☐ No	If yes, how much? _____ drinks per week.
Do you manage stress well?	☐ Yes	☐ No	☐ Not sure ☐ Need help
Do you exercise regularly?	☐ Yes	☐ No	If no, why not? _____
Do you sleep soundly?	☐ Yes	☐ No	If no, why not? _____

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____

HEALTH SCREENING HISTORY

List the date of your most recent test or exam.

Mammogram_____	Pap Smear_____	Abnormal Pap_____	Annual Physical_____
Blood test for Chol. _____	Blood Sugar_____	Other Blood tests_____	Eye Exam_____
Immunizations: Tetanus _____	Hepatitis_____	MMR_____	Flu Shot_____
Test for Blood in stool_____	Rectal Exam_____	Prostate / PSA Test_____	Colonoscopy_____

Patient Name: _____

PERSONAL AND FAMILY HISTORY

CHECK ALL THAT APPLY: **PLEASE CIRCLE (A) for alive or (D) for deceased for each family member below.**

Circle one →	SELF	FATHER A D	MOTHER A D	PATERNAL GRANDFATER A D	PATERNAL GRANDMOTHER A D	MATERNAL GRANDFATHER A D	MATERNAL GRANDMOTHER A D
AIDS							
Alcoholism							
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Birth Defects							
Bleeding Disorder							
Breast Cancer							
Cancer _____							
Cataracts							
Colon Cancer							
COPD							
Depression							
Diabetes							
Emphysema							
Epilepsy							
Gallbladder Disease							
Glaucoma							
Heart Attack							
Heart Trouble Please Specify_____							
High blood pressure							
High Cholesterol							
IBD							
IBS							
Kidney Disease							
Liver Disease							
Mental Illness							
Migraine Headaches							
Pneumonia							
Other Lung Disease							
Prostate Cancer							
Sickle Cell Anemia							
Stroke							
Suicide							
Tuberculosis							
Thyroid Disease							
Ulcers							

Do you have any siblings Brothers #_____ Sisters # _____ ☐ Healthy

Do you have any children Boys# _____ Girls # _____ ☐ Healthy

Please list any health issues for siblings / children:

_____

_____

Patient Name: _____

REVIEW OF SYSTEMS

Check any symptoms that **currently** apply to you:

Constitutional	**Mouth & Throat**	**Muscles, Bones & Joints**	**Digestion & Intestines**
☐ Poor appetite	☐ Tongue discoloration	☐ Neck pain	☐ Indigestion
☐ Fevers	☐ Bad breath	☐ Back pain	☐ Belching / flatulence
☐ Chills	☐ Teeth problems	☐ Muscle pain	☐ Difficulty swallowing
☐ Food craving	☐ Grinding teeth	☐ Painful joints: R___ L___	☐ Heartburn / ulcer
☐ Weight gain	☐ Tonsillitis / adenoids	☐ Shoulder _____ Elbow____	☐ Nausea
☐ Fatigue	☐ Facial pain	☐ Hip___ Knee___ Ankle___	☐ Liver Trouble
	☐ Sore throat	☐ Wrist_____ Fingers_____	☐ Vomiting
Eyes	☐ Ulceration tongue	☐ Joint Swelling_____	☐ Diarrhea
☐ Eye pain	☐ Gum bleeding	☐ Muscle weakness	☐ Cramping bowels
☐ Blurred vision		☐ Muscle cramps_____	☐ Food allergies
☐ Poor vision ___day	**Heart & Circulation**		☐ Constipation
☐ Poor vision ____night	☐ Chest pain	**Skin, Hair**	☐ Abdominal pain
☐ Wear corrective lenses	☐ Lightheadedness	☐ Psoriasis	☐ Rectal pain / Itching
☐ ___near___ far sighted	☐ Palpitations	☐ Warts	☐ Hemorrhoids / piles
☐ Other	☐ Cold hands / feet	☐ Freckles	☐ Blood in stool
	☐ Fainting	☐ Itching, Hives	
Ears, Nose	☐ Swelling feet	☐ Hair Loss	
☐ Ringing ears	☐ Blood clots	☐ Dry skin, Eczema	
☐ Nosebleed / polyp	☐ Varicose veins		**Women**
☐ Postnasal drip		**Nerves, Movement, Brain**	☐ Pelvic pain
☐ Sinus problems		☐ Seizures	☐ Vaginal discharge
☐ Trouble with taste/smell	**Breathing & Lungs**	☐ Nerve Pain	☐ Painful periods
☐ Poor hearing	☐ Shortness of breath	☐ Poor balance	☐ Premenstrual Syndrome
☐ Earaches / infections	☐ Wheezing or asthma	☐ Poor coordination	☐ Hot Flashes
☐ Sneezing / discharges	☐ Repeated colds / flu	☐ Tremors or shaking	☐ Itching or soreness
	☐ Cough dry / irritating	☐ Headaches	☐ Irregular Menses
Immune System			
☐ Too many infections		**Urine, Kidney, Bladder**	**Reproductive**
☐ Allergies to food	**Genital**	☐ Painful urination	Last Cycle Date _____
☐ Allergies to environment	☐ Sores on genitals	☐ Wake up to urinate ___ x per night	☐ Age period started_____
☐ Other concerns	☐ Lumps or swelling	☐ Kidney stones	☐ # of pregnancies _____
	☐ Erection problems	☐ Loss of control	☐ # abortions_____
Blood System	☐ Sexually Active	☐ Frequent urination	☐ # miscarriages_____
☐ Lymph gland swelling	☐ Pain with sex	☐ Sudden urging	☐ # of live births_____
☐ Anemia	☐ Exposure to STD	☐ Blood / pus urine	☐ Children currently living_____
☐ Easy bruising	☐ Repeated infections	☐ Urinary Tract Infection	☐ Age menopause_____

Southern Horizon Healthcare PLLC

2280 Highland Village Rd Ste 100, Highland Village TX 75077

(HIPAA Release Form) 2021

Health Insurance Portability and Accountability Act

Patient Name:_____ Date of Birth: ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

[ ] Spouse/Parent_____ Phone:_____

[ ] Child(ren)_____ Phone:_____

[ ] Other_____ Phone:_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ]my work [ ] my cell Number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ]_____

The best time to reach me in (day)_____ between (time) _____

Signed: _____ Date: ____/____/____

Witness:_____ Date: ____/____/____

Southern Horizon Healthcare PLLC
2280 Highland Village Rd., Ste 100
Highland Village, Texas 75077
469-645-0200

Missed Appointment Policy

Southern Horizon Healthcare has implemented a Missed Appointment Policy effective January 1, 2016. There will be a $50 missed appointment fee for appointments that are missed without notifying our office at least 24 hours in advance.

Your insurance company will **NOT** be billed for the missed appointment fee. You will be responsible for the fee of $50 regardless of your insurance plan.

This is an office wide policy that will assist us in becoming more efficient with our time and will allow us to offer missed appointment time slots to other patients.

Thank you,

Southern Horizon Healthcare

Please sign your name, print your name, print patient name and date of birth, as well as date this acknowledgment below.

_____	_____
Signature	Date
_____	_____
Printed Name	Date of Birth

Acknowledgement of Receipt of Notice of Privacy Practices

Southern Horizon Healthcare, PLLC reserves the right to modify the right to modify the privacy practices outlined in its notice.

Signature
I have received a copy of the Notice of Privacy Practices from the company referenced above.

Name of Patient (Print)

Signature of Patient

Date

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient

Southern Horizon
HEALTHCARE

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____ Date of Birth:_____

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, preventative exam or physical, lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the physician or the physician 's staff.

I understand and agree it is my responsibility and not the responsibility of the physician or the physician's staff to know if my insurance will pay for any medical service I receive.

I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amounts, usual and customary limit, or any other type of benefit limitation for the medical services I receive.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out-of-pocket expense to me. I understand this and agree to be financially responsible for all charges.

I understand and agree it is my responsibility to know if my PCP (primary care physician) choice has been process by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

Signature:_____ Date: _____
(Please sign here – Patient of Responsible Party)

Responsible
Party Printed Name: _____
(Please print name of Responsible Party if different from Patient)

ph: 469.645.0200 fax: 469.320.9550 w: southernhorizon.org
2280 Highland Villiage Road, Suite 100, Highland Village TX 75077

SOUTHERN HORIZON HEALTHCARE

CREDIT CARD AUTHORIZATION FORM

PATIENT NAME:_____

DATE OF BIRTH:_____

The purpose of this form is to authorize **Southern Horizon Healthcare (SHH)** to retain a valid credit card number on file for you as a patient. All patients are required to complete this form. This form will be kept confidential and only authorized staff will have access to the information. Please refer to our website www.southernhorizon.org for a copy of our Office Policies.

Your supplied credit card will be charged **ONLY** under the following circumstances:

1. SHH reserves the right to charge the credit card listed below for all current patient balances, including co-pays (following insurance payments) and a receipt will be kept in your patient chart, unless directed to send the receipt directly to you. **This notice serves as your consent to being charged for all current patient balances on your account.**

2. If you, as the patient, miss a scheduled appointment without a 24-hour notice to cancel or reschedule, SHH reserves the right to charge the credit card listed below $50 for our standard no-show fee and a receipt will be sent to the current address on file. **This notice serves as your consent to being charged for any and all no-show fees.** As is customary, a representative from SHH will call the phone number on file to remind you of your scheduled appointment. This reminder is usually done 24 hours prior to your scheduled appointment. It is the patient's responsibility to ensure we have a correct and current telephone number on file.

3. If we receive notice that a payment is returned to us for any reason, SHH reserves the right to charge the credit card listed below a $30 returned check fee as well as a $25 processing fee. A receipt will be sent to the current address on file. **This notice serves as your consent to being charged for any returned payments.**

4. If you, as a patient, request paper records we will provide to you, upon written request, a paper copy of your medical record. SHH reserves the right to charge our base fee of $30 to provide you with a copy of your records. **This notice serves as your consent to being charged for medical records request.**

5. If you, as a patient, receive a Fee for Service, this includes any medications, labs, procedures, supplies and other services **NOT** covered by your insurance and offered to you by SHH; we SHH, reserve the right to charge the credit card listed below for the cost of the services rendered according to your insurance policy.

Other than the conditions mentioned above, under NO circumstance will SHH charge your credit card for anything not discussed personally with you. In conjunction with HIPPA regulations, all credit card information will be confidentially kept within your account in our office. Only authorized staff will be able to access this information.

Acknowledged, Agreed & Accepted:

Having read this form and talked with the physician, and/or staff, my signature below acknowledges that I voluntarily give my authorization and consent to providing the requested information for my credit card to be charged accordingly for the conditions listed above.

X_____
Patient Signature (or person authorized to sign for patient) Date

X_____
Staff Signature Date

NAME AS IT APPEARS ON CREDIT CARD:

_____

BILLING ADDRESS:_____

_____

DISC/MC/VISA #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

EXPIRATION DATE: _____/_____

VERIFICATION CODE (3 or 4 digits): ___ ___ ___ ___

Refusal to Complete Authorization:

Refusal to complete and agree to this authorization dictates the following: Since there is no credit card on file with SHH, SHH reserves the right to send only ONE statement to the address on file to notify you of your balance with our practice. Please note, there may be a discretionary charge of $20 for this statement. It is your responsibility to send the amount due within 45 days of your statement to avoid being sent to collections and having your account closed with our practice.

X_____
Patient Signature (or person authorized to sign for patient) Date

X_____
Staff Signature Date