TRUSTED CARE CLINIC

PATIENT REGISTRATION

PATIENT INFORMATION

Today's Date: | Doctor:

Patient's Last Name: | First: | MI: | SSN: | (Office Use) MRN: | ○ New ○ Established

Is this your legal name? ○ Yes ○ No | If not, what is your legal name? | (Former Name): | Birth Date: / / | Age:

Sex: ○ M ○ F | Marital Status | Driver's License Number:

Street Address: | Apt. Number | City: | State: | ZIP Code:

Home Phone: | Mobile Phone: | Work Phone: X | Preference of Contact ○ Home ○ Work ○ Cell

E-mail Address*: | Race: ○ African-American ○ Asian ○ Caucasian ○ Hispanic ○ Other: | Ethnicity: ○ Hispanic, Latino, Spanish ○ Not Hispanic, Latino, Spanish | Primary Language Spoken:

Religious Affiliation (Optional): | Reason for Visit: | Referring Physician: | Primary Care Physician: | How did you hear about our office?:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): | Home phone : | Alternate Phone: | Relationship to Patient:

EMPLOYMENT

Employer: | Employer Street Address: | Employer City: | State: | Zip:

Employer Phone:

GUARANTOR INFORMATION

Guarantor Last Name: | First: | MI: | SSN: | Home Phone:

Guarantor Address: | Guarantor Employer: | Occupation:

City: | State: | Zip:

Guarantor Employer Address: | Work Phone:

City: | State: | Zip:

INSURANCE INFORMATION (PLEASE HAVE THE RECEPTIONIST COPY YOUR INSURANCE CARDS)

Primary Insurance Company: | Insurance Company Phone: | Address:

City: | State: | Zip:

Subscriber Name: | Subscriber SSN: | Subscriber Birth Date: / / | Policy Number:

Group Number: | Effective Date: / / | Relationship to Patient: | Subscriber Employer:

Secondary Insurance Company: | Insurance Company Phone: | Address:

City: | State: | Zip:

Subscriber Name: | Subscriber SSN: | Subscriber Birth Date: / / | Policy Number:

Group Number: | Effective Date: / / | Relationship to Patient: | Subscriber Employer:

The above information is complete and correct. I authorize treatment of the above named patient. I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to me to the doctor group indicated on the claim. All professional services rendered are charged to the patient. The Patient is responsible for all fees, regardless of insurance coverage. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due the doctor.

A copy of the signature is as valid as the original.

Patient Signature | *Date* | *Guarantor Signature* | *Date* | *Registered By:*

TRUSTED CARE CLINIC

PATIENT HISTORY

Name: _____ Date of Birth: _____

Medical Record Number: _____

PAST MEDICAL HISTORY:

Have you ever been diagnosed with any of the following?

	PATIENT HISTORY	FAMILY HISTORY
High Blood Pressure	____ Yes ____No	____ Yes ____No
Diabetes Mellitus (sugar)	____ Yes ____No	____ Yes ____No
Angina Pectoris (Chest Pain)	____ Yes ____No	____ Yes ____No
Heart Attack	____ Yes ____No	____ Yes ____No
Irregular Heart Beats	____ Yes ____No	____ Yes ____No
Hypertension	____ Yes ____No	____ Yes ____No
High Cholesterol	____ Yes ____No	____ Yes ____No
Blood Clots	____ Yes ____No	____ Yes ____No
Anemia (low blood count)	____ Yes ____No	____ Yes ____No
Stroke	____ Yes ____No	____ Yes ____No
Emphysema / COPD	____ Yes ____No	____ Yes ____No
Asthma	____ Yes ____No	____ Yes ____No
Other Breathing Problems: _____	____ Yes ____No	____ Yes ____No
Hepatitis	____ Yes ____No	____ Yes ____No
Hypothyroidism (Low Thyroid)	____ Yes ____No	____ Yes ____No
Arthritis	____ Yes ____No	____ Yes ____No
Kidney Stones	____ Yes ____No	____ Yes ____No

Other, please specify:

_____

_____

Cancer: ____ Yes ____No ____ Yes ____No

What kind: _____ When? _____

What kind: _____ When? _____

What kind: _____ When? _____

TRUSTED CARE CLINIC

PATIENT HISTORY

OBSTETRICS AND GYNECOLOGY HISTORY:

Last Menstrual Period: _____ Are you sexually active? _____Yes _____No
Please specify, if any, irregularities about your period:

_____

Child Birth: _____
Abortions, miscarriages, stillbirths, C-sections: _____

WHAT OTHER PROVIDERS DO YOU SEE? or HAVE YOU SEEN IN THE PAST?

Name: _____ Name: _____
Address:_____ Address: _____
Phone Number: _____ Phone Number: _____
Specialty: _____ Specialty: _____

Name: _____ Name: _____
Address:_____ Address: _____
Phone Number: _____ Phone Number: _____
Specialty: _____ Specialty: _____

PAST SURGICAL HISTORY:

Have you ever had any of the following operations? If so, when?

Appendectomy (Appendix)	_____Yes	_____No	_____ Date / Year
Tonsillectomy (Tonsil Removal)	_____Yes	_____No	_____ Date / Year
Cholecystectomy (Gallbladder)	_____Yes	_____No	_____ Date / Year
Hysterectomy (Uterus)	_____Yes	_____No	_____ Date / Year
Mastectomy (Breast Single or Bilateral)	_____Yes	_____No	_____ Date / Year
Bypass Surgery (Heart)	_____Yes	_____No	_____ Date / Year
Cataract Laser	_____Yes	_____No	_____ Date / Year
Hemorrhoidectomy (Hemorrhoids)	_____Yes	_____No	_____ Date / Year
Colectomy (Colon Removal)	_____Yes	_____No	_____ Date / Year
Hernia Repair	_____Yes	_____No	_____ Date / Year
Anesthesia Complications	_____Yes	_____No	_____ Date / Year

Other, please specify:
_____
_____

Recent ER Visit/Hospitalization? _____Yes _____No _____ Date
Date:_____ Reason: _____

Patient Name: _____
Date of Birth: _____

TRUSTED CARE CLINIC

PATIENT HISTORY

PRIOR EXAMS and IMMUNIZATIONS:

	DATES		
Exam	**1**	**2**	**3**
Periodic Health Exam			
EKG			
Cholesterol Test			
Chest X-ray			
Pap Smear			
Mammogram (Breast Exam)			
Prostate Exam			
Colonoscopy			
Sigmoidoscopy			
Stool Test (FOBT)			
Bone Mineral Density Test			
Diabetic Eye Exam			
Dental Exam			
Glaucoma Screening			

	DATE OF DOSE (mm/dd/yy)				
Vaccine	**1**	**2**	**3**	**4**	**5**
Polio					
DTP					
DT or Td					
MMR					
HIB Meningitis					
Mumps					
Rubella					
Measles					
Chicken Pox					
Tetanus					
HPV					
Pneumovax					
Hepatitis					
Zostavax					

Do you need any immunizations today? _____Yes _____No

CURRENT MEDICATIONS:

Medicine: _____ Dose: _____ (mg) How often_____

Medicine: _____ Dose: _____ (mg) How often_____

Medicine: _____ Dose: _____ (mg) How often_____

Medicine: _____ Dose: _____ (mg) How often_____

Medicine: _____ Dose: _____ (mg) How often_____

Medicine: _____ Dose: _____ (mg) How often_____

**Add additional medications to the back of this form*

Patient Name: _____

Date of Birth: _____

TRUSTED CARE CLINIC

PATIENT HISTORY

ALLERGIES:

Seasonal _____ Yes _____No Animals _____ Yes _____No

Medication _____ Yes _____No

Medicine: _____ Type of Reaction: _____

Medicine: _____ Type of Reaction: _____

Medicine: _____ Type of Reaction: _____

SOCIAL HISTORY:

Do you smoke? _____ Yes _____No How much/How long? _____

If stopped, how long ago? _____

Do you drink Alcohol? _____ Yes _____No How much? _____

If stopped, how long ago? _____

Substance Abuse? _____ Yes _____No How much? _____

If stopped, how long ago? _____

Do you exercise regularly? _____ Yes _____No How much? _____

Are you on any special diet? _____ Yes _____No What diet? _____

Do you need any special assistance?

_____ Yes _____No What kind? _____

Have you traveled outside of the country recently?

_____ Yes _____No What kind? _____

Do you live in more than one location throughout the year?

_____ Yes _____No

***Please remember to provide us with any alternate contact and provider information

Do you have Advanced Directives / Living Will _____Yes _____No

***Please bring a copy for your provider

_____ _____

DATE PATIENT SIGNATURE

Patient Name: _____

Date of Birth: _____

NAME: _____
DOB:_____

Functional Medicine Questionnaire

1. Hair Loss

a) Have you noticed your hair thinning? YES or NO
If so, how long have you noticed the thinning: _____Years _____Months

b) Have you noticed increased shedding? YES or NO
If so, how long have you noticed the shedding: _____Years_____Months

2. Thyroid Medical History
   a) Do you have a history of thyroid disorder? YES or NO (if no, continue to #3)
   If so, which one:
   __Hypothyroid
   __Hyperthyroid
   __Hashimoto's Thyroiditis
   __Cancer
   __Other:_____
   b) When were you diagnosed? _____
   c) Are you currently getting treated? YES or NO
   d) Are you currently euthyroid (are your thyroid hormone levels normal)? YES or NO
   e) Most recent TSH level:_____

3. Hormones (females)
   a) Do you have acne? YES or NO
   b) Do you have increased facial and/or chest hair growth? YES or NO
   c) Are your menstrual cycles normal: YES or NO
   d) Are you currently on birth control? YES or NO
   If so, which one: _____
   How long have you been on it? _____Years_____Months
   Were your periods normal before starting birth control? YES or NO
   Are your periods normal since having started birth control? YES or NO

4. Hormones (males)
   a) Are you currently taking Testosterone? YES or NO
   If so, how long have you been taking testosterone _____Years_____Months
   b) Are you losing hair? YES or NO
   c) Are you losing muscle mass? YES or NO
   d) Are you feeling tired? YES or NO
   e) Are you gaining weight in the mid-section? YES or NO
   f) Have you lost interest in sex and experiencing low libido? YES or NO

NAME: _____
DOB:_____

5. Sleep Apnea
    a) Do you snore? YES or NO
    b) Do you often feel tired, fatigued, or sleepy during daytime? YES or NO
    c) Do you have a history or diagnosis of sleep apnea? YES or NO
    D) are you interested in an alternative to a CPAP machine? YES or NO

Would you like the provider to discuss treatment methods for hair loss, hormone replacement therapy or snore reduction during today's visit? YES or NO
If yes, please circle the area of interest.

TRUSTED CARE CLINIC

HIPAA CONTACT DISCLOSURE

I,_____ (DOB)_____, give (Provider Name)_____

and staff, authorization to disclose my protected health information to the following family, friends and/or caregivers:

Name:_____Relationship:_____Phone:_____
Name:_____Relationship:_____Phone:_____
Name:_____Relationship:_____Phone:_____
Name:_____Relationship:_____Phone:_____

In the event VIP Primary Health Care may need to communicate your test results or medical information via telephone, please check all communication options below that may be used:

_____ Leave a detailed voice message on this phone, the number is_____
_____ Call you on your cellular phone, the number is_____
_____ Call you at work, the number is_____
_____ Speak to you directly. ONLY

Disclaimer: Certain sensitive health information (treatment/testing) are specifically protected and will not be disclosed outside of the clinic setting without specific authorization. This includes the following:

• Mental/behavioral Health records • Sexually transmitted disease (STD)

• Genetic testing/test results • HIV testing results/AIDS treatment
• Alcohol/drug dependency treatment

Please indicate if you allow or deny VIP Primary Healthcare the ability to share this information with you, per the indicated communication option above.

I allow VIP Primary Health Care to share sensitive health information as noted above per the communication options checked on this form. _____ (Patient Signature)

I DO NOT allow VIP Primary Health Care to share sensitive health information as noted above. _____ (Patient Signature)

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Medical Records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment, payment or healthcare operations as cited in the Notice of Privacy Practices. I understand that authorizing the disclosure of this health information is voluntary. P3 Health Partners Medical Group and its entities will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. If I have questions about the disclosure of my health information, I can refer to my Notice of Privacy Practices.

_____ _____
Signature of Patient Date

Signature of Guardian or Personal Representative _____

TRUSTED CARE CLINIC

AUTHORIZATION TO RELEASE MEDICAL RECORDS

(This authorization complies with HIPAA)

Printed Name of Patient (first, middle, last name)	**Birthdate (mm/dd/yyyy)**
Address (Street Address, City, State, Zip Code)	
Phone Number	**E-mail**

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, or family member to release all health information about me:

Person/Organization to Release Information		
Street Address		
City	**State**	**Zip Code**

The following person/organization is hereby authorized to receive my entire medical record, treatment record and diagnostic record to the following person or organization:

Person/Organization to Receive Information ARLENE RILLO, MD- VIP PRIMARY HEALTHCARE	
Street Address 3195 St Rose Parkway #212	**City,State,Zip** Henderson, NV 89052
Phone 702-342-1384	**Fax 702-342-1385**

I authorize the release of my entire medical record, except for the following (initialed):

_____Treatment of communicable diseases, including sexually transmitted diseases, venereal diseases, tuberculosis, or hepatitis HIV-Related Treatment

_____Mental Health Information or Psychological Conditions

_____ Alcohol or Substance Abuse Treatment Genetic Testing

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below.

Signature of Patient or Personal Representative	**Date Signed**

TRUSTED CARE CLINIC

TRUSTED CARE CLINIC
3417 Spectrum Boulevard
#200 Richardson, TX

Informed Consent to use Patient Portal

Trusted Care Clinic is offering this secure, HIPPA compliant communication tool as a courtesy to our patients. It is an optional service, and we reserve the right to suspend or terminate it at any time. We will alert you to any changes as promptly as possible. This form is intended to inform you of the facts and risks surrounding the use of the web portal. By signing below, you confirm that you have read, understand, and agree to comply with our procedures and guidelines for using the Patient Portal. You also agree not to hold Trusted Care Clinic or any of their staff liable for network infractions beyond their control.

Privacy and Security

The web portal or webpage has a secure tunnel connection with our clinic that uses encryption to keep unauthorized persons from being able to access and read your health information or your communications to us. To help ensure that the tunnel remains secure, we need to have your current (private) email address and be informed if it ever changes. Keep your portal user ID and password secure so that only you, or someone authorized by you, can gain access to patient information. If you think someone has learned your password, immediately go to the portal site, and change it. Your email address is confidential and protected information. With our best effort we will protect this information as we do your medical and personal information. We will never purposefully share this information with any third party. All access to our internal network and electronic medical records (EMR) is password protected. Our staff is instructed to logoff their workstations when not physically present. Additionally, in compliance with HIPAA guidelines, our EMR automatically logs the user out after a period of inactivity. Like phone communications, messages may be read and addressed by different clinical staff. When your provider is ill or on vacation, your emails will be addressed by a covering provider.

Confidential email, please print clearly: _____

Patient Name: _____ Date of Birth: _____

Print name of Parent/Guardian requesting access: _____

Signature: _____ Date: _____

TRUSTED CARE CLINIC

Consent to Obtain Patient Medication History

Patient Name: _____ DOB: _____

The purpose of this consent is for permission to obtain your medication history. Patient medication history is a list of prescription medicines that our providers or other providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribution to the collection of this history.

The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illnesses properly and in avoiding potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history may not include drugs purchased without using your health insurance. Also, over-the-counter drugs, supplements and/or herbal remedies that patients take on their own may not be included.

By signing this consent form you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to allow VIP Primary Health Care to obtain my medication history.

Patient Signature: _____ Date: _____

Personal Representative: _____ Relationship: _____

Staff Signature: _____ Date: _____

TRUSTED CARE CLINIC

Arrival Policy:

Patients are asked to arrive at their appointments before their scheduled time. **New patients** are to arrive 30-45 minutes early, while **established** patients are to arrive 15 minutes early. This allows enough time for the registration process to be completed before the actual appointment. If you arrive 10 minutes after your scheduled time, you will still be seen, but you will be limited to the remaining time of your scheduled appointment. We strive to accommodate our patients, but we also want to be respectful of the next patient's appointment, so we will not be able to extend your time beyond the allocated visit duration.

A grace period of 15 minutes will be permitted for unforeseen delays that a patient may encounter while traveling to the clinic for their appointment. If a patient arrives more than 15 minutes late for their appointment, they will be given the option of either being seen that day as a walk-in, if the schedule permits, or rescheduled for a later date. Please call our office if you need to utilize the grace period. This process will ensure that patients who do arrive on time are seen in a timely manner.

New patients are required to complete several forms and questionnaires to ensure a smooth transition of care. While we understand that you may have multiple concerns for the provider to address, for optimal care, it is essential to focus on only two (2) per visit. Please feel free to schedule a follow-up appointment to discuss additional concerns.

Cancellation Policy:

We ask that you give at least a 24 hour notice prior to cancelling your appointment.

1st NO SHOW will result in a 50$ charge prior to rescheduling.

2nd NO SHOW will result in a 100$ charge prior to rescheduling.

Self-insured patients

For cash paying patients if you miss your scheduled appointment without notification of at least 24hrs you will not be scheduled

NAME: _____

SIGNATURE: _____

DATE: _____