# Blanco Regional Clinic, PA

## PATIENT INFORMATION

NAME:_____DOB_____SS#_____

ADDRESS: _____CITY:_____ST_____Zip_____

HM#_____CELL#_____EMAIL_____

PREFERRED PHARMACY_____PH#_____

MARRIED SINGLE DIVORCED WIDOWED

**PLEASE SELECT ONE OF THE FOLLOWING:** WHITE BLACK HISPANIC ASAIN AMERICAN INDIAN OTHER

**INSURANCE:**
**POLICY HOLDER INFORMATION**:

NAME_____DOB_____

**ASSIGNMENT OF BENEFITS:**
Our office will file insurance for all reimbursable services to your primary insurance carriers. Please remember that you are responsible for all deductibles, co-pays, and non-covered services. These fees are due at the time of your office visit. I assign benefits to Blanco Regional Clinic, PA for all health service provided to me. I understand that BRC has the right to refuse or accept assignment of such benefits.

_____

Signature of patient or responsible party Date

**HIPPA INFORMATION**
I acknowledge that BRC, PA has provided me with a written copy of the Notice of Privacy Practices, and I have afforded the opportunity to read and ask questions about the Notice of Privacy Practices.
**May we release health information about you to family members or other individuals? Yes or No**
**If you answered yes, please list the names of each individual.**

_____

Name relationship phone

_____

Name relationship phone

_____

Name relationship phone

Patient signature_____ date_____

**PLEASE NOTE THAT IT IS THE RESPONSIBILTY OF THE PATIENT TO OR LEGAL GAURDIAN TO NOTIFY OUR OFFICE OF ANY OF THE ABOVE CONTACT INOFRMATION CHANGES.**

**PAST MEDICAL HISTORY**

PLEASE CIRCLE WHAT APPLYS

| | | |
|---|---|---|
| ACNE | GLAUCOMA | SEIZURES |
| ADD/ADHD | GOUT | SINUS INFECTIONS CHRONIC |
| ANEMIA | HEART CONDITION | SLEEP DISORDER |
| ANXIETY | Specify_____ | STD TYPE_____ |
| ASTHMA | HEPATITIS TYPE_____ | STOMACH ULCERS |
| BIPOLAR DISORDER | HIGH BLOOD PRESSURE | STROKE |
| BLOOD CLOT | KIDNEY DISEASE | THYRIOD DISEASE |
| CANCER TYPE_____ | KIDNEY INFECTIONS | TUBERCULOSIS |
| CHRONIC BRONCHITIS | KIDNEY STONES | ULCERATIVE COLITIS |
| COLON POLYPS | LUPUS | WARTS |
| CHRON'S DISEASE OR IBS | MIGRAINES | |
| DEMENTIA | OSTEOARTHRITIS | |
| DEPRESSION | OSTEOPENIA | |
| DIABETES | OSTEOPOROSIS | |
| DIVERTICULITIS | PROSTATE PROBLEMS | |
| EATING DISORDER | REFLUX (HEARTBURN) | |
| ECZEMA | RHEUMATOID ARTHRITIS | |
| EMPHYSEMA | ROSACEA | |
| FREQUENT UTI'S | SCHZOPHRENIA | |
| GALLSTONES | SEASONAL ALLEGIES | |

**SURGICAL HISTORY**

| **SURGERY** | **YEAR** | **COMPLICATIONS** |
|---|---|---|
| - | - | - |
| - | - | - |
| - | - | - |
| - | - | - |
| - | - | - |
| - | - | - |

**PLEASE LIST DATE OF LAST EXAM:**

COLONOSCOPY_____ BONE DENISITY_____ PNEUMONIA VACCINE_____ FLU VACCINE_____

MAMMOGRAM_____ PAP_____ EYE EXAM_____ DENTAL EXAM_____ PROSTATE_____

COVID VACCINE_____ Tdap_____

**FAMILY HISTORY**

| Disease | Specificity | family member | cause of death Yes or No? |
|---|---|---|---|
| Cancer | | | |
| Diabetes | | | |
| heart disease (specify) | | | |
| Genetic | | | |
| Psych | | | |
| | | | |
| | | | |
| | | | |

## SOCIAL HISTORY

Do you have a living will, DNR or medical power of attorney? Yes or no

Do you exercise? Y or N How often?_____

Are you sexually active? Y or N Birth Control used: none condoms pill other_____

Do you smoke? Y or N If so how many packs a day _____how long _____if you quit what year_____

Do you consume alcohol? Y or N How many drinks day or week?_____

Do you consume Caffiene? Y or N How many a day?_____

Do you use illegal substances? Y or N if so what type_____

## CURRENT MEDICATIONS

| DRUG NAME | STRENGTH | HOW OFTEN DO YOU TAKE IT |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**MEDICATION ALLERGIES**

| DRUG NAME | REACTION |
|---|---|
| | |
| | |
| | |

**Blanco Regional Clinic, P.A.**

**825 Fourth St.**

**Blanco, TX 78606**

**830-833-5581**

## Date_____

# Mid-Level Provider Consent Form

**This practice utilizes Physicians Assistants (PAs) and Nurse Practitioners (FNPs) to provide health care. PAs and FNPs are educated, licensed, and nationally certified providers that work in conjunction with supervising Physician. There is on-going communication between the Physician and the Mid-Level providers regarding patient care. If at any time a patient requests an appointment with the Physician, this request will be granted at the first availability.**

**I voluntarily consent to evaluation and treatment by the Physician, Physician Assistant, or family Nurse Practitioner on staff at Blanco Regional Clinic, P.A. I understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of treatments or examination by the staff.**

**I have read the above information regarding Mid-Level Providers. I hereby give my consent of treatment.**

Patient Name:_____DOB_____

Signature_____