Blanco Regional Clinic, PA

PATIENT INFORMATION FOR MINOR

NAME:_____DOB_____SS#_____

ADDRESS: _____CITY:_____ST_____Zip_____

HM#_____CELL#_____EMAIL_____

PREFERRED PHARMACY_____PH#_____

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

GAURANTOR INFORMATION

INSURANCE:

POLICY HOLDER INFORMATION:

NAME_____DOB_____PHONE_____

Address:_____City_____ST_____Zip_____

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

Parent 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.

CURRENT MEDICATIONS

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

MEDICATION ALLERGIES PLEASE LIST

_____

_____

PAST MEDICAL HISTORY

PLEASE CIRCLE WHAT APPLYS

ACNE	ECZEMA
ADD/ADHD	FREQUENT UTI's
ANEMIA	REFLUX (HEARTBURN)
ANXIETY	SEASONAL ALLERGIES
ASTHMA	SEIZURES
BIPOLAR DISORDER	SINUS INFECTIONS
CHRONIC BRONCHITIS	STD TYPE_____
DEPRESSION	STOMACH ULCERS
DIABETES	
EATING DISORDER	

SURGICAL HISTORY

SURGERY	YEAR
-	-
-	-
-	-

Any complications during birth?_____

IMMUNIZATION HISTORY:

PLEASE PROVIDE US WITH A COPY OF RECORD

FAMILY HISTORY

Please list

relation	conditon

SOCIAL HISTORY

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_____

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_____