HCM | MEDICAL GROUP

Patient Information

Last Name	First Name	Middle Initial	DOB

Gender ☐ Male ☐ Female	Social Security Number	Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Home Phone	Cell Phone	Email Address

Physical Address	City	State	Zip Code

Mailing Address (If different from above)	City	State	Zip Code

Race (please select):
□ White □ American Indian or Alaska Native □ Asian □ Hispanic □ Black or African American □ Native Hawaiian or Pacific Islander □ Other □ Decline

Ethnicity (please select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline	Preferred Language (please select one): □ English □ Spanish □ Other: _____

Primary Care Physician	Phone Number	Fax Number

Referring Physician	Phone Number	Fax Number

Preferred Pharmacy	Phone Number	Fax Number

Responsible Party/Guarantor ☐ Same as Patient

If the patient is a minor (under the age of 18), the parent/guardian accompanying the patient will be listed as the responsible party/guarantor.

Last Name	First Name	Middle Initial	Relationship to Patient

DOB	Social Security Number	Phone Number	Email Address

Address (If different from patient address)	City	State	Zip Code

Emergency Contact

If the patient is a minor (under the age of 18), this section may be used for another parent/guardian.

Last Name	First Name	Phone Number	Relationship to Patient

Insurance Information

Please present insurance cards at time of check in – if you do not have your insurance cards at the time of your appointment, please complete the following:

Primary Insurance Name:	**Secondary Insurance Name:**
Claims Mailing Address:	Claims Mailing Address:
Phone Number:	Phone Number:
Policy Holder Name:	Policy Holder Name:
Policy Holder DOB:	Policy Holder DOB:
Policy Holder Social:	Policy Holder Social:
ID Number:	ID Number
Group Number:	Group Number

Advanced Directives

☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐ Living Will ☐ Healthcare Proxy

I hereby authorize employees and agents of Hill Country Memorial Medical Group (including physicians, physician assistants, nurse practitioners, and other employees) to render medical evaluations and care to the patient indicated. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency. I hereby authorize payment directly to Hill Country Memorial Medical Group for any surgical and/or medical benefits, if any, otherwise payable to me. I authorize Hill Country Memorial Medical Group to release medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand such records may include information regarding HIV/AIDS testing, substance abuse and/or mental health issues. I understand that I am financially responsible for all charges incurred for medical services which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to Hill Country Memorial Medical Group.

Signature	Date	Relationship to Patient

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Patient Name	DOB

Consent to Treat/Financial Responsibility/Privacy Practice Acknowledgement/Patient Portal

I hereby authorize employees and agents of Hill Country Memorial Medical Group (including physicians, physician assistants, nurse practitioners, and other employees) to render medical evaluations and care to the patient indicated. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

Initial _____ Date _____

I hereby assign all medical and/or surgical benefits, to which I am entitled, including Medicare, private insurance, and other plans to Hill Country Memorial Medical Group for medical services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that I am financially responsible for all charges incurred for medical services which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to Hill Country Memorial Medical Group.

Initial _____ Date _____

I acknowledge that I have received Hill Country Memorial Medical Group's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

Initial _____ Date _____

I understand that Hill Country Memorial Medical Group will automatically register me for a secure patient portal account using the email address provided. **Initial _____ Date _____**

No-Show Policy

"No-Shows" have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient "no-shows" a scheduled appointment it potentially jeopardizes the health of the "no-showing" patient, is unfair (and frustrating) to the other patients that would have taken the appointment slot, and disrespects not only the provider's time, but also the time of the entire clinic staff.

To Avoid Getting a "No-Show"

- **Confirm your appointment** – HCM Medical Group will attempt to contact you three business days prior to your appointment to confirm, cancel, or reschedule your appointment.
- **Arrive 5-10 minutes early** – Please arrive 5-10 minutes prior to your appointment to allow time for completion of your check-in.
- **Give 24 hour notice to cancel or reschedule your appointment** – Please contact our office no later than 24 hours before the scheduled visit.

After three or more "no-shows" within a one year period, you may be dismissed from the care of your medical provider.

- If you are dismissed from the care of your medical provider, your remaining scheduled appointments will be cancelled.
- Only emergency medical treatment will be offered within the first 30 days of dismissal.

I certify that I have read the HCM Medical Group "No Show" Policy, understand its contents, and agree to the terms outlined above.

Initial _____ Date _____

Prescription History

I voluntarily consent to provide HCM Medical Group access to and use of my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes. I understand that my prescription history (which includes but is not limited to prescriptions, labs, and other health care drug historical information) from unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my medical provider. I acknowledge that HCM Medical Group may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

Initial _____ Date _____

Patient Name	DOB

Request for Confidential Communication

I authorize HCM Medical Group (HCMMG), and its assignees, including and not limited to its authorized agents, affiliates, and contractors, to utilize all contact information I have provided to communicate with me. I hereby grant permission and consent to HCMMG, and its assignees, including and not limited to its authorized agents, affiliates, and contractors to communicate with me via phone call or text messaging. **Initial _____ Date _____**

I wish for the following individuals to be allowed to access my information *verbally*:

Name: _____ Phone Number: _____ Relationship to Patient: _____
Authorized to Access: □ Billing Information □ Medical Condition Information

Name: _____ Phone Number: _____ Relationship to Patient: _____
Authorized to Access: □ Billing Information □ Medical Condition Information

Name: _____ Phone Number: _____ Relationship to Patient: _____
Authorized to Access: □ Billing Information □ Medical Condition Information

Initial _____ Date _____

Designation of Authorized Adult to Consent to Medical Treatment for Minor Patients

I do hereby state and represent that I have legal custody of the minor patient listed below and that I have the authority to consent to any and all medical/surgical care of said minor. By signing below, I grant my authorization and consent for the Designated Adult(s) listed below to accompany the minor to HCM Medical Group (HCMMG) locations for medical care and treatment. I state that the Designated Adult(s) listed below are at least 18 years of age and competent to make decisions on my behalf. I authorize the Designated Adult(s) to consent to any treatment for the minor that is covered under HCMMG's consent to treat that I have previously signed, including, but not limited to, routine medical examination and treatment, immunizations, and counseling. I agree to assume financial responsibility for all expenses of the minor's medical care authorized by the Designated Adult(s). I understand that the healthcare provider, at his or her discretion, may require a parent or legal guardian to be present for certain non-emergent medical treatments, and in such cases, I may be required to accompany the minor. I further understand that this authorization does not authorize the Designated Adult(s) to give written consent to the use or disclosure of the minor's protected health information, as those terms are defined by federal law.

I understand that I may change or revoke this authorization at any time by notifying HCMMG in writing.

Patient Name: _____ Patient DOB: _____

Designated Authorized Adult(s):

Name: _____ Phone Number: _____ Relationship to Patient: _____

Name: _____ Phone Number: _____ Relationship to Patient: _____

Name: _____ Phone Number: _____ Relationship to Patient: _____

Parent/Legal Guardian Signature	Printed Name	Date

Patient Paperwork

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Patient Name: _____

Date: _____

Current Weight:
Current Height:

MEDICATIONS - List all medications you take, prescription and non-prescription, and the dosage

□ I do not take any medications □ I have a list I will provide separately

Medication Name	Dosage	Frequency	For	Prescibed by

If more space is needed, please attach full list of medications on a separate sheet of paper.

MEDICAL HISTORY - Check if you are or have ever experienced the following conditions

	Condition		Condition		Condition
□	Alcoholism	□	Depression	□	Learning Disability/Delay
□	Anemia	□	Diabetes	□	Liver Disease
□	Anxiety	□	Diverticulitis/Diverticulosis	□	Neuropathy
□	Arthritis	□	Eye Disease	□	Obesity
□	Asthma	□	Fibromyalgia	□	Osteoporosis
□	Atrial Fibrillation	□	GERD	□	Pancreatitis
□	Autoimmune Disease	□	Gout	□	Peripheral Vascular Disease
□	Bleeding Disorder	□	Hearing Loss	□	Prostate/BPH
□	Cirrhosis	□	Heart Attack	□	Renal Disease
□	Colon Cancer	□	Hepatitis A / B / C	□	Rheumatoid Arthritis
□	Colon Polyps	□	High Cholesterol	□	Sleep Apnea
□	Congestive Heart Failure	□	Hitatal Hernia	□	Stroke/TIA
□	COPD/Emphysema	□	HIV/AIDS	□	Thyroid Disease
□	Coronary Artery Disease	□	Hypertension	□	Ulcerative Colitis
□	Crohn's Disease	□	Irritable Bowel Syndrome	□	Other

MEDICATION AND FOOD ALLERGIES - List all known allergies and intolerances (drugs, food, animals, latex, etc.)

□ No Known Allergies

Allergy	Reaction

Patient Name: _____

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SURGICAL HISTORY - List any serious injuries or surgical procedures, and approximate year.								
Procedure		Year	Procedure		Year	**Procedure**		Year
□	Appendectomy		□	Heart Surgery (Type):		□	Pacemaker	
□	Aneurysm					□	Prostate	
□	Bladder					□	Reflux Surgery	
□	Bowel Surgery		□	Hemorrhoid Surgery		□	Skin Surgery	
□	Brain		□	Hernia Surgery		□	Spinal Surgery	
□	Breast		□	Hysterectomy		□	Stent Placement	
□	CABG		□	Joint replacement:		□	Sterilization; Type	
□	Carotid					□	Testicles	
□	Carpal Tunnel					□	Thyroidectomy	
□	Colonoscopy		□	Kidney		□	Tonsillectomy	
□	Cosmetic Surgery		□	Liver Biopsy		□	Transplant Surgery	
□	C-Section		□	Liver Surgery		□	Upper Endoscopy (EGD)	
□	ERCP		□	Lung Surgery		□	Valve Replacement	
□	Eye Surgery		□	Orthopedic Surgery:		□	Varicose Veins	
□	Gallbladder Surgery					□	Other	
□	Gastric Surgery					□	Other	

HOSPITALIZATIONS - Non-surgical, please provide reason	
Date_____	Reason: _____
Date_____	Reason: _____
Date_____	Reason: _____
Date_____	Reason: _____

FAMILY MEDICAL HISTORY							
□ Adopted	Mother	Father	Sibling:	Sibling:	Sibling:	Child	Child
Living	□	□	□	□	□	□	□
Deceased	□	□	□	□	□	□	□
Deceased Age:							
Barrett's Esophagus	□	□	□	□	□	□	□
Colon Polyps	□	□	□	□	□	□	□
Inflammatory Bowel Disease	□	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□	□
Heart Disease	□	□	□	□	□	□	□
High Cholestrol	□	□	□	□	□	□	□
Hypertension	□	□	□	□	□	□	□
Liver Disease	□	□	□	□	□	□	□
Mental Disorder	□	□	□	□	□	□	□
Stroke	□	□	□	□	□	□	□
Other	□	□	□	□	□	□	□
Cancer:	□	□	□	□	□	□	□
Breast	□	□	□	□	□	□	□
Esophagus	□	□	□	□	□	□	□
Lung	□	□	□	□	□	□	□
Uterine, Bladder, Ureter	□	□	□	□	□	□	□
Pancreas	□	□	□	□	□	□	□
Prostae	□	□	□	□	□	□	□
Stomach	□	□	□	□	□	□	□
Other	□	□	□	□	□	□	□

Patient Name: _____

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Caffeine/Tabacco/Drug/Alcohol Use	Do you currently use tabocco products? □ Yes □ No			For how long? _____	
	□ Cigarettes ____ packs per day	□ Cigar/Pipe ____ amount per day		□ Chewing ____ amount per day	
	Have you ever tried to quit? □ Yes □ No				
	Have you previously used tobacco products? □ Yes □ No			For how long?	
	□ Cigarettes	□ Cigar/Pipe	□ Chewing	When did you quit?	
	Alcohol Use:	□ Yes □ No			
	Beer:	□ Occasional	□ Weekly	□ Daily	□ Never
	Wine:	□ Occasional	□ Weekly	□ Daily	□ Never
	Liquor:	□ Occasional	□ Weekly	□ Daily	□ Never
	Do you consume drinks containing Caffeine? □ Yes □ No				
	If yes, how many drinks do you consume per day _____				
	Drug use:	□ Yes □ No	Type _____	Last Usage _____	
	Have you ever been treated for addiction?		□ Yes □ No		

Personal	Education	
	How many children do you have?	How many children at home?
	Type of Exercise? _____	□ Daily □ Weekly □ Monthly □ Yearly
	Lives With	
	Occupation	□ Full Time □ Part time
	Religious Preference	

Vaccines	Last Flu Vaccination	Date
	Last Pneumonia (Circle: Prevar 13 and/or Pneumovax 23) Vaccination(s)	Date
	Last Shingles (Zostavax) Vaccine	Date
	Last Tetnus (Circle: Tdap or Td) Vaccine	Date
	HepatitisB Vaccine, Did you complete the series? □ Yes □ No	Dates:

Screenings	Last Breast Cancer Screening (Mammogram)	Date
	Last Abdominal Aortic Aneurysm (AAA) Screening	Date
	Last Lung Cancer Screening	Date
	Last Bone Density Screening (DEXA)	Date
	Last Prostate Cancer Screening (PSA)	Date

Testing	Diagnostic Testing - List any imaging you have had pertaining to the curent issues					
		Ultrasound	CT Scan	MRI	Labs	Other
	Date					
	Where					

Specialists	Please list all doctors you currently see			
	Name	Specialty	Address	Phone