



PATIENT INFORMATION

Name: _____ Date of Birth _____

Address: _____ City: _____ State: _____ Zip _____

Primary Phone (_____) _____ Secondary Phone (_____) _____ Other Phone (_____) _____

SS# _____ - _____ - _____ Email address _____

Race _____ Ethnicity _____ Preferred language _____

Marital Status Minor Single Married Widowed Separated Divorced

Person to contact in case of emergency _____ Phone _____ Relationship _____

Preferred pharmacy _____ Location: _____

How did you hear about us? _____

INSURANCE INFORMATION

Name of Insured (if other than self) _____ DOB _____

Insured SSN#: _____ Relationship to Patient _____

Financial Responsibility/Assignment of Benefits

As a courtesy to you, our office will file insurance for all reimbursable services to both your primary and secondary insurance carriers. While we do our best to accurately predict your insurance coverage, sometimes our estimates are inaccurate due to circumstances beyond our control. Should your insurance not pay as we expect, or does not pay in a timely manner, you will be responsible for the unpaid portion of your charges.

I assign to C. Kelly Family Clinic, PA, any insurance, or other third party benefits available for health care services provided to me. I understand that C. Kelly Family Clinic, PA has the right to refuse or accept assignment of such benefits.

I have been given the opportunity to read the clinic's patient policies and procedures. The policies are available upon request.

Signature of Patient or Responsible Party _____ Date _____

HIPAA INFORMATION

Protected health information (PHI) will only be released from our practice with a properly executed authorization from the patient or his/her personal representative, except for treatment, payment, or health care operations and as otherwise required by law. Examples of some instances in which we are required to disclose your PHI include: Public health activities; information regarding victims of abuse, neglect, or domestic violence; health oversight activities; judicial and administrative proceedings; law enforcement purposes; organ donations purposes; research purposes under certain circumstances; national security and intelligence; and correctional institutions. **C. Kelly Family Clinic, PA** will only use or disclose PHI, except as noted above, consistent with the terms of the authorization.

I understand that I have the right to review the notice of Privacy Practices that provides a more complete description of information uses and disclosures.

Kelly Family Clinic may share my PHI with the following additional person(s): _____

Signature _____

Date _____



Past Medical History

None

- | | | |
|---|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Frequent Sinus Infections | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Reflux (Heartburn) |
| <input type="checkbox"/> Blood Clot | <input type="checkbox"/> Gout | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Condition Specify_____ | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Seizures |
| What kind?_____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> STD |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Crohn's Disease or IBS | <input type="checkbox"/> Kidney Infections | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Migraines | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Other:_____ |
| <input type="checkbox"/> Frequent UTI's | <input type="checkbox"/> Osteoporosis | |

Surgical History

Grandparent
 Sibling
 Mother
 Father

Family History

Mental Health History

- | | Year | Grandparent | Sibling | Mother | Father | Family History | Mental Health History |
|--|-------|--------------------------|--------------------------|--------------------------|--------------------------|---|---|
| <input type="checkbox"/> Appendectomy | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Heart Disease/Attack | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Back Surgery | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Stroke | <input type="checkbox"/> Anxiety Disorder |
| <input type="checkbox"/> Cataract Surgery | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Cesarean Section | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Gallbladder Surgery | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Heart Surgery | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Sleep Disorder |
| Specify_____ | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Depression | <input type="checkbox"/> None |
| <input type="checkbox"/> Hemorrhoid Surgery | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Hernia | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Hysterectomy | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Migraines | |
| <input type="checkbox"/> Joint Surgery_____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Other Illness:_____ | |
| _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Colon Cancer | |
| <input type="checkbox"/> Lumpectomy | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Prostate Cancer | |
| <input type="checkbox"/> Plastic Surgery | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Lung Cancer | |
| <input type="checkbox"/> Polyp Removal (Colon) | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Breast Cancer | |
| <input type="checkbox"/> Tonsillectomy/Adenoidectomy | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Uterine Cancer | |
| <input type="checkbox"/> Tubal Ligation or Vasectomy | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Ovarian Cancer | |
| <input type="checkbox"/> Other | _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Skin Cancer | |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Other Cancer:_____ | |

None



Authorization to Release Medical Records

I authorize my prior physician, _____, to release my ENTIRE medical records to Dr. Kelly.

My prior physician's information:

Phone: _____

Fax: _____

This information is to be disclosed
by either fax or mail to:

Kelly Family Clinic
66 Gruene Park Dr., Ste. 109
New Braunfels, TX 78130

Phone: 830-214-6411

Fax: 830-626-8800

My information:

Patient's Name: _____

Date of Birth: _____

I authorize the release of my entire medical record to Kelly Family Clinic in order to transfer care. I understand my medical record may contain sensitive information such as mental health, HIV, AIDS, substance abuse, sexual abuse and/or other related conditions.

I understand that I may withdraw or revoke this permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying Kelly Family Clinic in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by the Federal of Texas privacy regulation.

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization if requested. A photocopy of this authorization is as valid as the original.

Signature of Patient or Legal Guardian

Date

Printed name



Physician Assistant Consent for Treatment

This facility has on staff a physician assistant to assist in the delivery of medical care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the Texas Medical Board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of, and accepting responsibility for the medical services provided.

A physician assistant may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulation a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above, and hereby consent to the services of a physician assistant for my health care needs.

I understand that at any time I can refuse to see the physician assistant and request to see a physician.

Signature

Date