KELLY FAMILY CLINIC
Family Medicine & Obstetrics

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 _____

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Past Medical History

- ☐ **None**
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Blood Clot
- ☐ Blood Transfusion
- ☐ Cancer
  What kind?_____
- ☐ Chicken Pox
- ☐ Colon Polyps
- ☐ Crohn's Disease or IBS
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Eczema
- ☐ Frequent UTI's
- ☐ Frequent Sinus Infections
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Condition Specify_____
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Kidney Infections
- ☐ Kidney Stones
- ☐ Migraines
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Prostate Problems
- ☐ Psoriasis
- ☐ Reflux (Heartburn)
- ☐ Rheumatoid Arthritis
- ☐ Rosacea
- ☐ Seizures
- ☐ STD
- ☐ Stomach Ulcers
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tuberculosis
- ☐ Ulcerative Colitis
- ☐ Warts
- ☐ Other:_____

Surgical History

	Year
☐ Appendectomy	_____
☐ Back Surgery	_____
☐ Cataract Surgery	_____
☐ Cesarean Section	_____
☐ Gallbladder Surgery	_____
☐ Heart Surgery Specify_____	
☐ Hemorrhoid Surgery	_____
☐ Hernia	_____
☐ Hysterectomy	_____
☐ Joint Surgery	_____
☐ Lumpectomy	_____
☐ Plastic Surgery	_____
☐ Polyp Removal (Colon)	_____
☐ Tonsillectomy/Adenoidectomy	_____
☐ Tubal Ligation or Vasectomy	_____
☐ Other	_____

☐ **None**

Family History

Family History	Grandparent	Sibling	Mother	Father
Heart Disease/Attack	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Hypothyroidism	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Other Illness:_____	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐
Uterine Cancer	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐
Skin Cancer	☐	☐	☐	☐
Other Cancer:_____	☐	☐	☐	☐

Mental Health History

- ☐ ADD/ADHD
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Eating Disorder
- ☐ Sleep Disorder

☐ **None**

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Social History

Highest Level of Education: ☐ Less than 8th grade ☐ Less than High School ☐ High School ☐ College ☐ Graduate school ☐ Professional

What type of work do you do? _____

Are you sexually involved? ☐ Yes ☐ No

If you have any children, please list their names and ages: _____

_____

What hobbies or activities do you enjoy? _____

Do you exercise? ☐ Yes ☐ No If so, what type and how often?_____

Do you have a living will? (Do not resuscitate or medical power of attorney) ☐ Yes ☐ No

Is there concern for your safety? (Emotional, physical, or sexual abuse) ☐ Yes ☐ No

Tobacco Use	Caffeine/Alcohol Use		Street Drug Use
☐ Never Smoked	**Alcohol**	**Caffeine**	☐ Never Used Street Drugs
☐ Ex-Smoker Quit Date_____	☐ None	☐ None	☐ Past Use
☐ Current Smoker	☐ 2 or less/day	☐ 3 or less/day	☐ Current Use
☐ Current Smoke Exposure	☐ 3 or less/day	☐ 4 or more/day	
☐ Smokeless tobacco use			
	☐ History of problems with alcohol		

Current Medications

Include Over the counter medications and food supplements. Continue on back page if needed. If you do not take medications, please check "None." ☐ **None**

Medication Name	Dose	How Often

Medication Allergies

Include any medication to which you have had a reaction. ☐ **None**

Medication Name	Reaction

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Establish Dates and Menstrual History

First day of last period _____ Is this date: ☐ Definite ☐ Approximate ☐ Unsure

Are your periods usually regular each month? ☐ Yes ☐ No

Were you using birth control in the last 3 months? ☐ Yes ☐ No

Have you had a positive pregnancy test? ☐ Yes ☐ No Where? _____ When? _____

Have you had care elsewhere for this pregnancy? ☐ Yes ☐ No Where? _____ When? _____

How many times have you been pregnant? (Including this pregnancy) _____

How many deliveries? _____ Vaginal _____ C section _____

How many miscarriages? _____ Abortions _____ How many living children? _____ Age(s)_____

List any problems with past pregnancies_____

Last pap smear _____ Have you ever had an abnormal PAP smear? ☐Yes ☐No

Age of first period _____

Number of days between each period _____ Number of days your period lasts _____

Baby's father's name _____

Infection History

☐ Yes ☐ No Do you live with someone with TB or been exposed to TB?

☐ Yes ☐ No Have you had a rash or viral symptoms since your last period?

☐ Yes ☐ No Do you or your partner have a history of genital herpes?

☐ Yes ☐ No Have you ever had Hepatitis B or Hepatitis C?

☐ Yes ☐ No Do you have a history of sexually transmitted disease? (Chlamydia, gonorrhea, HPV, HIV, syphilis)

Which one(s)_____

Genetic History

What is your ethnic group? _____ Father's ethnic group _____

Does anyone in you or your partner's family have any of the following genetic problems?

☐ Down Syndrome	☐ Kidney problems	☐ Canavan Disease	☐ Frequent Miscarriages
☐ Cystic Fibrosis	☐ Spina Bifida	☐ Hemophelia	☐ Stillbirths
☐ Autism	☐ Sickle Cell	☐ Blood disorders	☐ Huntingtons Chorea
☐ Mental retardation	☐ Type 1 Diabetes	☐ Thalassemia	☐ Other Birth Defect
☐ Heart problems	☐ Tay Sachs	☐ Muscular dystrophy	☐ Neural Tube Defect

Social History

☐ Yes ☐ No Are you planning on going to prenatal classes? Where?_____

☐ Yes ☐ No Are you planning on breastfeeding?

☐ Yes ☐ No Do you have any objections to blood transfusion if needed?

☐ Yes ☐ No Are you interested in permanent sterilization after this pregnancy?

☐ Yes ☐ No Do you have any cats or take care of cats?

☐ Yes ☐ No Do you wear a seatbelt?

☐ Yes ☐ No Do you ever feel afraid of someone in your family or any of your friends?

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Review of Systems

In order for the provider to get a complete picture of your health today, please answer all the questions based on how you are feeling today or the past few days.

General
- ☐Y ☐N Feeling well
- ☐Y ☐N Fetal Movement
- ☐Y ☐N Headache
- ☐Y ☐N Vision changes/spots/blurring

Gastrointestinal
- ☐Y ☐N Nausea
- ☐Y ☐N Vomiting
- ☐Y ☐N Diarrhea
- ☐Y ☐N Constipation
- ☐Y ☐N Abdominal Pain

Musculoskeletal
- ☐Y ☐N Back Pain

Genitourinary
- ☐Y ☐N Vaginal bleeding
- ☐Y ☐N Vaginal discharge
- ☐Y ☐N Leakage of fluid
- ☐Y ☐N Contractions
- ☐Y ☐N Burning with urination

KELLY FAMILY CLINIC
Family Medicine & Obstetrics 66 Gruene Park Dr., Ste. 109 New Braunfels, TX 78130 (830)214-6411 www.kellyfamilyclinic.com

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:_____

My information:

Patient's Name:_____

Date of Birth:_____

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

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

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Primary/Secondary Insurance Verification

In an effort to continue to provide exceptional healthcare services, it is important that we receive payment for services rendered. In the process of billing and collecting from your insurance provider, there are times when payment is delayed or refused due to the lack of information in their files to show that they are the only insurance providing coverage to you, the beneficiary. A statement from you is required stating that there is no other coverage. To prevent delays, we ask that you complete this form so that we can file with your insurance carrier. This will help you in ensuring your claims are paid. We appreciate your help with this matter.

Patient's Name:

Patient Date of Birth:

I hereby certify that there is **no** other current coverage for the patient listed above.

--OR--

I hereby certify there **is** other current coverage for the patient listed above, and this policy is listed below and is **not** the primary insurance.

Patient's other/secondary insurance information:

Insurance Company Name:_____

Insurance ID #:_____

Group #: _____

Policy's Holder's Name: _____

Patient's relationship to policy holder: _____

Policy Holder's date of birth: _____

1. Are you covered by any other insurance such as Medicare, Medicaid, TriCare, or policies from your employer under a group health plan? _____

2. Are you covered under an insurance plan carried by your spouse or family member? Yes No

_____ _____

Signature Date

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Newborn Insurance Intent

Please initial the following statements.

___I understand after my baby is born, I will be responsible for providing health insurance for the baby.

___I understand my insurance will **not** automatically add my baby to my policy, and that I must call the insurance company to add my baby.

___I understand if I do not add my baby to an insurance policy, I will be responsible for all hospital charges and vaccines given during the first few weeks of life, which can add up to over $3000.

___ I understand even if my baby becomes eligible for Medicaid, Dr. Kelly will not bill Medicaid for these services, and that I will still be responsible for payment.

___I am planning to add my baby to **ONE** of the following:

- ☐ My current policy
- ☐ Another policy held by _____
  - Policy number_____
  - Group number_____
- ☐ No insurance
- ☐ Other (explain)_____

_____ _____

Signature Date

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Newborn Immunization Intent

Please initial the following statements:

___ I understand that Dr. Kelly will be my baby's pediatrician both in the hospital after delivery and for follow-up well child visits in the clinic.

___ I understand that Dr. Kelly requires all patients to be fully immunized.

___ I agree that my child will be immunized according to the schedule recommended by the CDC.

___ I understand that if I choose to follow a different schedule or to not immunize my child, Dr. Kelly will be unable to treat my child for any healthcare.

_____ _____

Signature Date

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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

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Cystic Fibrosis Testing Consent

What is cystic fibrosis (CF)?
Cystic fibrosis (CF) is one of the most common inherited disease About 1 in 3300 live-born children in the United States have CF. It is common in Caucasians, but can occur in other ethnic or racial backgrounds.

CF causes the body to produce large amounts of abnormally thick mucus, which collects in several organs. In the lungs, it leads to congestion and pneumonia. Mucus may also collect in the intestines, resulting in diarrhea and poor growth. Treatment for these problems often requires staying in the hospital for one or two weeks at a time. Although CF is present from birth, the symptoms may not appear until later in childhood, or in some people until teenage or adult years. CF does not affect intelligence.

There is no cure for CF at this time. Scientists are, however making progress in improving treatment and in searching for a cure. In the past, people with CF died very young, but now many are living longer lives.

Who could be a carrier of CF? Anyone could a CF carrier. Being a carrier does not cause health problems.

If there is no one in your family with CF, your risk of being a CF carrier is determined by your ethnic background. The population risks, may vary slightly amount different laboratories, are summarized below:

If you are:	**Your chance of being a CF carrier is:**
Caucasian	1/25 to 1/29
Ashkenazi Jewish	1/26 to 1/29
Hispanic	1/46
African American	1/60 to 1/65
Asian American	1/90

If someone in your family has CF, then no matter what your ethic background, your change of being a carrier is increased. The change is greater if the person with CF is a close relative. Your specific risk can be determined from your family history by a doctor or by a genetic counselor.

How can you find out if you are a CF carrier? There is now a DNA test which can detect most of the people who are CF carriers. The test can be done on a small sample of blood or on a sample obtained with a small brush rubbed on the inside of the person's mouth. It takes amount 2 weeks to get the results, and the test can detect 30-97% (depending on ethnic background) of all CF carriers. In every population, some CF carriers will be missed by the test.

What if your test results show you are a CF carrier? If your test shows you have one CF gene, then you are a CF carrier. The test has greater than 99 percent accuracy. This result does not affect your own health.

If one member, of the couple is a CF carrier and the other is not, then the risk is less than 1 in 1000 (0.1 percent) the child would have CF.

- If both parents are CF carriers, the risk is 1 in 4 (25%) – with each pregnancy – that the child would be effected.
- If only one member of the couple has been tested and is found to be a carrier, the other member of the couple should be tested as soon as possible.

The information from the test may benefit you in your family planning. The information may also have implications for family members. If you are a CF carrier, your relatives may also be carriers and should be offered testing.

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Is there prenatal testing for CF? Yes. The same CF test is done on blood or cheek brush samples can also be done on prenatal samples (amniotic fluid or chorionic villi). The accuracy of the prenatal test is greatest when both parents have had a CF carrier testing. Accurate interpretation of the prenatal test also depends on knowing the man tested is in fact the father of the unborn baby.

Prenatal testing for CF is appropriate when:

- Both parents of the pregnancy are CF carriers.
- Ultrasound (sonogram) of the fetus shows blocked intestines, a possible sign of CF. In this case, blood samples from both parents should be sent for testing along with the amniocentesis sample.
- There are any other at-risk-situations. Talk to your doctor.

Why should you sign a consent form for CF Testing? It is standard to sign a consent form for any DNA test. By signing, you are showing that you have been informed about the medical purpose of the test and its limitations. As with any DNA testing, it is possible that non-paternity (someone who is not the real father) will be discovered, or some other previously unknown information about family relationships. Also, some individuals have been denied insurance coverage based on results from DNA testing.

Will insurance cover the cost of the carrier test? Health plan and insurance coverage may vary. It is best to ask your plan representative before having the carrier test.

Informed consent/Decline for Cystic Fibrosis (CF) carrier status testing:
The decision to be tested for CF is completely yours.

1. I understand the test does not detect all carries.
2. I understand if I am a carrier, testing the baby's father will help me learn more about the chance my baby could have CF.
3. I understand if one parent is a carrier and the other is not, it is still possible the baby will have CF, but this chance is very small.
4. I understand if bother parents are carriers, additional testing can be done in order to know whether or not the baby will have CF.
5. I understand if the baby has inherited a changed CF gene from each, the only way to avoid birth of a baby with CF is by terminating the pregnancy.

☐ I do not want Cystic Fibrosis carrier testing.
☐ I want Cystic Fibrosis carrier test.

_____ _____
Signature Date