RANDOLPH FAMILY MEDICINE
DR. MARK B. RANDOLPH

1920 CORPORATE DRIVE SUITE 208
SAN MARCOS, TEXAS 78666

PHONE 512-878-6330
FAX 512-878-6941

Patient Registration Information

A copy of your drivers' license and insurance card are also needed for your chart. It is the patients' responsibility to keep personal (name, address, and phone number) and insurance information current with our office. Thank you!

Date: _____

Last Name _____ First Name _____Middle _____

Address _____ Apt # ____ City _____ State_____ Zip _____

DOB _____ Sex: M F SSN _____ Marital Status _____

Race_____ Ethnicity_____ Language: English Spanish Other_____

Drivers License # _____ EXP _____

Home # _____ WK # _____ Cell # _____

Email Address _____ Employed By _____

Emergency Contact
You consent for us to contact this person in the event of an emergency.

Name _____

Relation to Patient _____ Phone # _____

Address _____Apt #_____

City _____ State _____ Zip _____

Cardholder/Responsible Party
(If it is not yourself)

Name _____

Phone # _____

Address _____ Apt # _____

City _____ State _____ Zip _____

DOB _____SSN _____

Relationship to Patient _____

Employed by _____

Pharmacy/Phone _____

Advance Directives
Do you have a Living Will? _____ If yes, please list the location of the Living Will or contact person

_____.
A copy is also recommended for your chart, if over age 65.

How did you hear about us _____

Turn over to complete patient registration. Thank you!

Acknowledgement of Review of Practice Policy and Procedure
The Office Policy, Collection, and Billing Procedure is located in the folder behind this form.

I acknowledge I have read the office's Policy and Procedures, a copy maybe requested. I understand there will be a ***$25 charge for any appointment missed or not rescheduled within 24 hours of appointment time.***

There will be a charge for filling out forms or for writing letters.

_____ _____

Signature Date

Insurance Authorization and Assignment

I hereby authorize Dr. Mark Randolph to furnish information to my insurance carrier(s) concerning my illnesses and treatment. I will be responsible to the physician for all payments of medical services not covered by insurance. I hereby authorize that photocopies of this form are as valid as the original.

Dr. Randolph is required by his contracts with the insurance carriers to collect all co pays, deductibles, and coinsurance at the time of service.

Payment is required at the time of service.

_____ _____

Signature Date

ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS

By signing below, you acknowledge that you have received/read this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

I do _____ I do not _____ authorize Randolph Family Medicine to leave a message with available persons at my home _____, work _____, cell phone _____ phone number, on my answering machine, or with the emergency listed above.

Patient Name: _____ Patient Date of Birth: _____
(Please Print Name)

SIGNATURES: Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____

Witness (optional) : _____ Date:_____

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Patient Name: _____ DOB: _____ Date: _____

Medical History Form

	Patient	Mother	Father	Siblings	Grandmother Father side	Grandfather Father side	Grandmother Mother side	Grandfather Mother side
Allergies								
Arrhythmia								
Asthma								
Carotid Artery Stenosis								
Congestive Heart Failure								
COPD								
Coronary Artery Disease								
Diabetes								
GERD								
Headaches, Migraines								
Hyperlipidemia								
Hypertension								
Hypothyroidism								
Iron Deficiency, Anemia								
Obesity								
Osteoarthritis								
Osteoporosis								
Peptic Ulcer								
Cancer: _____								
Other: _____								
Other: _____								

Hospitalizations

Reason	Date

Surgeries

Reason	Date

Medication Allergies O NKDA

_____

_____

Medications – Bring Medication Bottles to appointment

Drug	Dosage	Directions

Immunizations

When was your last Tetanus? _____

If you are under the age of 18, please provide the office with a copy of your shot record.

Women- Please list last date of…

Pap Smear_____ Mammogram _____

Bone Density_____ Colonoscopy_____

Men- Please list last date of…

PSA _____ Colonoscopy_____