

**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: _____

NOTICE: This sample **Notice of Privacy Practices** was prepared by the Texas-based law firm of Jackson Walker, L.L.P. Any questions regarding this material are subject to the following paragraph and should be directed to your own legal counsel or to Jeffery Drummond at (214) 953-5781. The Texas Medical Association (TMA) has no responsibility for the content of this material and makes no representation regarding the accuracy, currency, or completeness of this information. Jackson Walker, L.L.P. and TMA provide this information as a commentary on legal issues with the understanding that it is not intended to provide advice on any specific legal matter. Due to the specific circumstances of a particular medical practice, some providers may be subject to other requirements not covered by the provisions of this document (for example, certain covered entities dealing with substance abuse treatment services will also be subject to the requirements of 42 CFR Part 2 disclosure restrictions), and should consult their own attorney. This information should NOT be considered legal advice and receipt of it does not create an attorney- client relationship. **This is not a substitute for the advice of an attorney.** Jackson Walker, L.L.P. and TMA provide this information with the express understanding that 1) it does not create an attorney-client relationship with you, 2) neither TMA, Jackson Walker, L.L.P. nor its attorneys are engaged in providing legal advice to you, and 3) that the information is of a general character. Although Jackson Walker, L.L.P. and TMA have attempted to present materials that are accurate and useful, some materials may be outdated, and Jackson Walker, L.L.P. and TMA shall not be liable to anyone for any inaccuracy, error or omission, regardless of cause, or for any damages resulting therefrom. Any legal forms are only provided for the use of physicians in consultation with their attorneys. You should not rely on this information when dealing with personal legal matters; rather, legal advice from retained legal counsel should be sought.

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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

Medications – Bring Medication Bottles to appointment

Drug	Dosage	Directions

Surgeries

Reason	Date

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 _____

Medication Allergies O NKDA

