

**RANDOLPH FAMILY MEDICINE  
DR. MARK B. RANDOLPH**

1921 CORPORATE DRIVE SUITE 102  
SAN MARCOS, TEXAS 78666

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

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**Patient Registration Information**

**A copy of your drivers' license and insurance card are also needed for your chart. 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** \_\_\_\_\_

**Acknowledgement of Review of  
Notice of Privacy Practices**

**The Private Policy Act is located in the folder behind this form.**

I acknowledge I have read this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**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 copays, deductibles, and coinsurance at the time of service.

*Payment is required at the time of service.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
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

**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.

**Medication Allergies O NKDA**

\_\_\_\_\_  
\_\_\_\_\_