SUNRISE FAMILY CLINIC

6725 Atascocita Rd
Humble Tx 77346

First Name: _____ Last Name: _____

DOB: _____/_____/_____ Age: _____ Phone Number: _____/_____/_____

Address: _____

City: _____ State: _____ Zip Code: _____

Gender: F____ M ____ Social Security Number: _____

Email: _____

Race: ___ American Indian or Alaska Native ___ Hispanic or Latino _____ White

___ Asian ___ Black or African American ___ Native Hawaiian or other Pacific Islander

Marital Status: ___Single ___ Married ___Divorced __Widow

Emergency Contact

First Name: _____ Last Name: _____

Phone Number: _____Relation to Patient: _____

How do you know about the clinic?

___Referral ___Flyer ___Facebook ___Instagram ___Passing by ___Atascocita.com

Other: _____

****Pharmacy:*** **_____** **Adress/Zip Code: _____**

Primary Insurance Information: Card Provided to MD Office: Yes ___ No ____

Name of Primary Insured: _____ DOB: _____

ID Number: _____ Group Number: _____

Insurance Company: _____

I AUTHORIZE SUNRISE FAMILY CLINIC TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS FOR SERVICES PROVIDED. I AUTHORIZE PAYMENT OF GOVERNMENT/ MEDICAL BENEFITS TO SUNRISE FAMILY CLINIC FOR SERVICES PROVIDED. I UNDERSTAND THAT I REMAIN RESPONSIBLE FOR ANY AND ALL CHARGES NOT MET BY MY INSURANCE COMPANY.

SIGNATURE _____ **DATE** _____

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TELEMEDICINE PATIENT CONSENT FORM

Patient Name: _____ Date: _____

DOB: _____

Description of Telemedicine, I understand that the telemedicine requires a healthcare provider, to communicate information interactively through video equipment, about my health, including past medical history, present symptoms, laboratory and diagnostic data.

1. Details of your medical history, examinations, x-ray, and tests may be discussed with other health professionals through the use of interactive video, audio and telecommunications technology.
2. Visual and physical examination of you may take place.
3. Nonmedical (technical personnel) may be requested to enter the area where telemedicine is being performed.
4. Video, audio, and/or photo recordings may be taken during the the encounter(s), (with your previous notification)
5. On the benefits and risks of telemedicine
6. . (174.5.b Regulation) telemedicine allows provide quality services without having to travel long distances, but in turn presents some risks below.

   a) There is a risk despite our best efforts to protect the privacy of patient information, that the security protocol may fail causing a violation of the privacy of personal medical information.

   b) There is a risk of a delay in diagnosis and medical treatment due to unexpected failures of electronic equipment for this service.

   c) I understand that if telemedicine consultation cannot be done, I will be referred to another health professional for a consultation or query will be scheduled in person. (174.5.c) of the Regulation)
7. I understand that I can withdraw my consent at any time to participate in this therapeutic means and then refer me to another health professional.
8. Any dissemination of patient-identifiable images or information and certain necessary administrative and operational activities supporting your care shall not occur without your authorization.

   By signing below, I understand the written information provided above, and voluntarily and freely agree give my consent to take part in the telemedicine and evaluation, assessment, and diagnosis for my current medical condition.

Signature of Patient/ legal Representative. _____

If signed by someone other than the patient, indicate relationship: _____

Mark (X) appropriate Box

The patient was evaluated by the provider at _____: _____ AM/PM The Patient has been previously evaluated by the provider.

Patient Signature: _____

Witness Signature: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Last Name _____ First Name _____ D.O.B. ___/___/_____

I understand that as a part of my health care, Sunrise Family Clinic maintains paper and /or electronic records describing my medical history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment.

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing its content
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how health information may be used or disclosed to carry out treatment, payment, or healthcare operations

I understand that Sunrise Family Clinic reserves the right to change its notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Consultation Sunrise Family Practice change the *Notice of Privacy Practices*, and amended version will be provided.

I wish to have the following restrictions to use or disclosure of my health information

I_____ authorized Sunrise Family Clinic to release any medical information about me include (labs results and x-ray) to_____

Relation With patient: _____.

I understand as a part of this organization's treatment, payment, or physical therapy operations, it may become necessary to disclosure my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via facsimile.

I fully understand and ACCEPT / DECLINE the terms of this consent

_____ _____

Patient Signature or Authorized Representative Date

Nurse Practitioner (N.P) Consent Form

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This facility has on staff a N.P to assist in the delivery of medical care, N.P is a graduate of a certified training program by the state board. Under the supervision of a Physician a N.P can diagnose, treat, and monitor acute and chronic diseases as well as provider health maintenance care. Supervision does not required the constant physical presence of the supervising physician, rather the overseeing of activities of and accepting responsibilities for the medical services provided .A N.P 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
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Offering counseling and education
- Supplying samples medications and writing prescription
- Making appropriate referrals

I _____ have read the above, and hereby consent to the services of a N.P for my health care needs .I understand that at any time I can refuse to see N.P

And request to see a Physician.

_____ _____

Patient (Guardian) Signature Date

List all current medications (including non-prescription medications: _____

_____

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List all allergies to medication: _____

Social History

Sexual Orientation: Straight or Heterosexual ____ Lesbian, Gay, Or Homosexual ____ Bisexual ____

Something else, please describe _____ Don't Know_____

	Yes	No	
Do you smoke?	__	__	Packs per week_____
Do you drink alcohol?	__	__	Amount _____
Do you exercise?	__	__	Times per week _____

Do you take nutritional supplements_____?

Current Occupation: _____

Hobbies: _____

Are Both Parents Alive? If not, reason of Passing. _____

How many siblings?_____

Preventive Care:

Date of Last Physical:_____

Date of Last Eye Exam:_____

Date of Last Pap Smear:_____

Date of Last Mammogram:_____

Date of Last Colonoscopy:_____

Date of last Menstrual Cycle:_____

Any Implantable devices:_____

Have you ever had any surgeries? If so, please list:

_____

Witness (For clinic use only)_____

Medical and Family History/Review of Systems (mark yes if applicable)

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	Patient	***Family***		***Patient***	***Family***
High blood pressure	Yes/No	Yes/No	Hepatitis	Yes/No	Yes/No
Heart condition	Yes/No	Yes/No	Tuberculosis	Yes/No	Yes/No
Congestive heart failure	Yes/No	Yes/No	AIDS	Yes/No	Yes/No
Stroke	Yes/No	Yes/No	Positive HIV	Yes/No	Yes/No
Diabetes	Yes/No	Yes/No	Lupus	Yes/No	Yes/No
Bleeding disorder	Yes/No	Yes/No	Arthritis/Join pain	Yes/No	Yes/No
Anemia	Yes/No	Yes/No	Thyroid Disease	Yes/No	Yes/No
Asthma	Yes/No	Yes/No	Bladder Disease	Yes/No	Yes/No
Emphysema	Yes/No	Yes/No	Kidney Disease	Yes/No	Yes/No
Chronic Cough	Yes/No	Yes/No	Ulcer	Yes/No	Yes/No
Sinus/Allergies	Yes/No	Yes/No	Chronic constipation	Yes/No	Yes/No
Headaches	Yes/No	Yes/No	Chronic diarrhea	Yes/No	Yes/No
Migraines	Yes/No	Yes/No	Weight loss/gain	Yes/No	Yes/No
Seizure disorder	Yes/No	Yes/No	Depression	Yes/No	Yes/No
Hearing problems	Yes/No	Yes/No	Cancer	Yes/No	Yes/No
Autoimmune Disease	Yes/No	Yes/No			

Patient Signature: _____ Date: _____

Provider signature: _____