SPACE CENTER PRIMARY CARE, PLLC
PATIENT REGISTRATION

Legal name: Last _____First _____M.I._____

Preferred name: _____Date of Birth:___ _____ Gender: M / F / non-binary

Address: _____

Preferred phone: _____ Home / Cell / Work Other phone _____

Other phone:_____ Email: _____ SS# _____

Family status: Dependent Child / Single / Married / Divorced / Widowed / Other_____

Employment: Full Time / Part Time / Retired / Unemployed / Disabled

Employer/school:_____

Address:_____Phone:_____

How did you find out about us? _____

In case of emergency, notify:

1)_____Phone_____Relation_____

2)_____Phone_____Relation_____

RESPONSIBLE PARTY / GUARANTOR

Name of person responsible for medical bills_____

Address:_____

Date of Birth: _____/_____/_____ SS# _____Phone: _____

Relationship to patient: _____ Email: _____

INSURANCE INFORMATION

Are you covered by health insurance? _____ If no, please make payment arrangements with our business office.

Primary Insurance:_____ Policy#: _____ Group #:_____

Policy Holder Name:_____ Policy Holder Date of Birth:_____

Social Security Number: _____ Copay: $_____

Patient's Relation To Policy Holder: _____ Employer:_____

Secondary Insurance:_____ Policy#: _____ Group #:_____

Policy Holder Name:_____ Policy Holder Date of Birth:_____

Social Security Number: _____ Copay: $_____

The above information is true to the best of my knowledge. I hereby authorize the payment of medical benefits billed to my insurance by Space Center Primary Care, PLLC. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time services are rendered. I also accept responsibility for fees that exceed the payment made by my insurance, if Space Center Primary Care, PLLC does not participate with my insurance. I hereby authorize Space Center Primary Care, PLLC to use and/or disclose my health information, which specifically identifies me or which can reasonably be used to identify me, to carry out treatment, payment, and healthcare operations.

I understand that while this consent is voluntary, if I refuse to sign this consent, Space Center Primary Care, PLLC can refuse to treat me. I understand this authorization can only be revoked in writing. If I revoke my consent, such revocation will not affect any actions that Space Center Primary Care, PLLC took before receiving my revocation.

Signature of Patient or Patient's Representative:_____Date_____

Printed Name of Patient: _____ Relationship of representative to patient: _____

Space Center Primary Care, PLLC
907 Bay Area Blvd, Ste B
Houston, TX 77058

PHYSICAL EXAM CONSENT FORM

Space Center Primary Care, PLLC puts the patient first by providing outstanding service to each and every patient, each and every visit. In keeping with our practice of educating our patients, we would like to inform you that if you are scheduled for a physical exam this will include routine blood work.

It's important to remember that anything your provider treats as a problem during your routine exam changes the visit to a problem-oriented one. Any test performed that doesn't relate to the routine physical exam will be applied to your copay/deductible and any costs associated with the additional services billed to insurance.

If there are complicated medical issues that you would like to discuss with your physician that fall outside of a routine physical exam, you can be scheduled for a separate appointment at another date/time where the provider can address these concerns. If your problem is emergent, we will address the problem today but will be required to reschedule the annual physical exam.

Here is a list of issues commonly discussed at a routine annual physical exam:

- Refilling your current prescriptions
- Discussing cardiovascular risk
- Discussing cancer screenings
- Recommended vaccines
- Updates and referrals to/from specialists
- Routine blood work

If you have any questions or concerns regarding this policy, please feel free to discuss with our staff.

_____ _____

Patient Signature Date

SPACE CENTER PRIMARY CARE, PLLC
INITIAL VISIT

NAME_____**BIRTHDATE**_____

THE ISSUE(S) FOR TODAY'S DOCTOR'S VISIT IS/ARE:

1)_____2_____3)_____

ALLERGIES TO MEDICATIONS_____

WHAT MEDICAL PROBLEMS HAVE APPLIED OR CURRENTLY APPLY TO YOU? __ **NO MEDICAL PROBLEMS**

CARDIOVASCULAR
__HIGH BLOOD PRESSURE
__HIGH CHOLESTEROL / LIPIDS
__CORONARY ARTERY DISEASE
__ ATRIAL FIBRILLATION (A FIB)
__OTHER ARRHYTHMMIA
__VASCULAR DISEASE
__VALVE DISORDER
__HEART FAILURE
METABOLIC/ENDOCRINE
__DIABETES
__HYPOTHYROIDISM (LOW)
__HYPERTHYROIDISM (HIGH)
__VITAMIN D DEFICIENCY
__VITAMIN B12 DEFICIENCY
__GASTRIC BYPASS / BARIATRIC SURG
RESPIRATORY
__TOBACCO USE / DEPENDENCE
__NASAL ALLERGIES
__SLEEP APNEA
__ASTHMA
__COPD
GASTROINTESTINAL
__ACID REFLUX (GERD)
__HEMORRHOIDS
__IRRITABLE BOWEL SYNDROME
__FATTY LIVER
__CIRRHOSIS
__CROHN'S / ULCERATIVE COLITIS
__COLON CANCER
NERVOUS SYSTEM
__MIGRAINE / OTHER HEADACHE
__ NEUROPATHY
__SEIZURES (EPILEPSY)
__STROKE
__DEMENTIA
JOINTS / SPINE
__OSTEOARTHRITIS
__HERNIATED DISC / SPINAL STENOSIS
__ROTATOR CUFF INJURY
__KNEE MENISCUS INJURY
__GOUT
__RHEUMATOID ARTHRITIS
__LUPUS
HEMATOLOGIC
__ON BLOOD THINNER (EX. WARFARIN)
__ANEMIA
__IRON DEFICIENCY
__LEUKEMIA/LYMPHOMA
__DEEP VEIN CLOT (THROMBOSIS)
INFECTION
__TAKING LONG-TERM ANTIBIOTICS
__HOSPITALIZED FOR INFECTION
__HEPATITIS B OR C
SKIN
__ECZEMA
__HERPES OUTBREAKS
__FUNGAL SKIN/NAIL INFECTION
__SKIN CANCER
KIDNEY/BLADDER
__KIDNEY STONES
__CHRONIC KIDNEY DISEASE
__INCONTINENCE
MENTAL HEALTH
__DEPRESSION
__ANXIETY
__DIFFICULTY SLEEPING (INSOMNIA)
__ADD/ADHD
__BIPOLAR DISORDER
__ALCOHOL ABUSE/DEPENDENCE
__DRUG ABUSE/DEPENDENCE
CHRONIC PAIN MANAGED WITH…
__NSAIDS / MUSCLE RELAXER
__OPIOID OR NARCOTIC
__MULTIPLE INJECTIONS
__SURGERY
WOMEN'S HEALTH
__ON BIRTH CONTROL
__HEAVY MENSTRUAL BLEEDING
__OSTEOPOROSIS
__ESTROGEN REPLACEMENT
__POLYCYSTIC OVARIAN SYNDROME
__BREAST CANCER
MEN'S HEALTH
__TESTOSTERONE REPLACEMENT
__LARGE PROSTATE (BPH)
__PROSTATE CANCER

OTHER DIAGNOSES _____

OTHER DOCTORS YOU SEE REGULARLY_____

RECENT HOSPITALIZATION / ER / URGENT CARE_____

MAJOR SURGERIES YOU'VE HAD_____

CURRENT MEDICATIONS:

1)_____ 4)_____ 7)_____

2)_____ 5)_____ 8)_____

3)_____ 6)_____ 9)_____

FAMILY HISTORY_____

SMOKING: __ packs/day __age when started __have quit before __already quit

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (S164.508(a))

I understand that as part of my healthcare, Space Center Primary Care, PLLC originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I have been provided with a copy of the *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment, it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (s164.506(a))

I understand that:

- I have the right to review Space Center Primary Care, PLLC's Notice of Information practices prior to signing this consent;
- that this Practice reserves the right to change the notice and practices and that prior to implementation will make a copy of any notice to the address I've provided if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except that this Practice has already taken action in reliance thereon.

Patient Name (Printed): _____ Date: _____

Signature of Patient or Legal Representative Witness: _____