WOODLANDS DIAGNOSTIC CLINIC

PATIENT REGISTRATION FORM

Today's Date: _____ SSN: _____ Doctor: _____

Patient Name: _____ Date of Birth: _____
(last name) (first name) (initial) (mm/dd/yyyy)

Maiden Name: _____ Gender: ☐ **M** ☐ **F** Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**
(if applicable) (check one) (check one)

Mailing Address: _____
(street/p.o. box) (city) (state) (zip code)

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Employer: _____ Occupation: _____

Employer Address: _____
(street/p.o. box) (city) (state) (zip code)

Home Email: _____ Work Email: _____

Spouse Name: _____ Spouse DOB: _____
(if applicable) (last name) (first name) (initial) (mm/dd/yyyy)

Emergency Contact: _____ Contact Phone: _____
(**same as above**, if spouse) (last name) (first name) (initial)

How did you hear about WDC? **Internet Search** **Social Media** **Print Ad** **Radio/Television** **Referral** _____
(circle one) (provide name, if referral)

IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT, PLEASE COMPLETE THIS SECTION

Name: _____ SSN: _____ Date of Birth: _____
(mm/dd/yyyy)

Relationship to Patient: _____ Contact Phone: _____

Mailing Address: _____
(street/p.o. box) (city) (state) (zip code)

Employer: _____ Work Phone: _____

NOTICE TO PATIENTS REFERRED TO IMAGING SERVICES

By my signature below, I acknowledge that Federal and Texas law requires physicians to disclose financial or ownership interests in referring entities. WDC owns the imaging center operated by the clinic in our building. Consequently, when you are referred to our imaging center for testing, the clinic and/or your referring physician may derive a financial benefit. As there are other suppliers available to offer similar services, you are free to use other suppliers of these services, if you so prefer. Please refer to the enclosed packet for alternate imaging service providers.

CONSENT FOR COMMUNICATION VIA EMAIL

Woodlands Diagnostic Clinic is dedicated to keeping your medical record information confidential. I understand that this office is not responsible for information loss or delay or for breaches in confidentiality that are due to technical factors beyond this office's control. By my signature below, I agree that Woodlands Diagnostic Clinic may send my medical related correspondence to me via email and that they may respond to my email communication using the Home Email address listed above.

ACKNOWLEDGEMENT AND REVIEW OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have reviewed or have had the opportunity to review Woodlands Diagnostic Clinic's Notice of Privacy Practices, which explain how my medical information will be used and disclosed. I understand that I am entitled to a copy of this document.

LATE ARRIVAL / CANCELLATION / NO-SHOW POLICY

By my signature below, I acknowledge that I may be charged a fee of $50 (not covered by insurance) for missing my appointment, arriving more than 15 minutes late, or cancelling my appointment without 24 business hours notice unless written proof of extenuating services is provided.

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION FOR RELEASE OF INFORMATION

By my signature below, I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Woodlands Diagnostic Clinic for any services furnished to me by one of the providers associated with practice. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA), its agents, and/or my Medigap or other insurer any information needed to determine these benefits or the benefits payable for related services. This authorization shall continue until such time as I revoke it in writing.

_____ _____
Signature Witness (if applicable)

WOODLANDS DIAGNOSTIC CLINIC

HEALTH HISTORY FORM

Today's Date: _____ SSN: _____ Date of Birth: _____

Patient Name: _____ Doctor: _____
(last name) (first name) (initial)

List Allergies and Reactions	
Allergy	Reaction

List Hospitalizations, Surgeries or non-WDC Physician Visits in the Last 12 Months		
Date	Event Description	Reason for Event

Occupation: _____ Marital Status: **Single** **Married** **Divorced** **Widowed** (circle one) Children: _____ (how many)

Do you smoke? ☐ **N** ☐ **Y** Packs Per Day: _____ If you smoke, are you interested in quitting: ☐ **Y** ☐ **N**

Did you stop smoking? ☐ **N** ☐ **Y** Packs Per Day: _____ When did you quit smoking? _____

Do you consume alcohol? ☐ **N** ☐ **Y** ☐ **Beer** ☐ **Wine** ☐ **Liquor** ☐ **Other** _____ How much per week? _____

Do you consume caffine? ☐ **N** ☐ **Y** ☐ **Coffee** ☐ **Tea** ☐ **Soda** ☐ **Other** _____ How much per week? _____

PERSONAL HEALTH HISTORY *(please check all items pertaining to your personal health history)*

☐ **Diabetes**
☐ Insulin Dependent ☐ Non Insulin Dependent Date and provider of last eye exam: _____

☐ **Diabetic Complications** Date and provider of last foot exam: _____
☐ Diabetic Retinopathy (*eye problems*) ☐ Diabetic Neuropathy (*nerve problems*)
☐ Diabetic Ulcers ☐ Diabetic Glaucoma, Cataract or Blindness ☐ Amputation(s) Associated with Diabetes
☐ Peripheral Vascular Disease or Circulation Problems due to Diabetes
☐ Other: _____

☐ **Heart Disease**
☐ Heart Attack or Myocardial Infarction When: _____
☐ Irregular Heart Beat ☐ Angina Stable or Unstable ☐ Chest Pain ☐ Palpitations
☐ Congestive Heart Failure or Edema ☐ Other Heart Disease: _____
Are you currently seeing a cardiologist? ☐ **N** ☐ **Y** Cardiologist Provider: _____

☐ **High Blood Pressure**
☐ Controlled ☐ Uncontrolled

☐ **Peripheral Vascular Disease**
☐ Circulatory Problems ☐ Other Circulatory Disorders
☐ Blood Clots or DVT ☐ Edema or Swelling or Pain in Legs
☐ Coagulation Disorder Are you on Coumadin or another blood thinner? ☐ **N** ☐ **Y** Brand: _____

☐ **Respiratory**
☐ Chronic Asthma ☐ Emphysema
☐ Allergic Asthma ☐ Shortness of Breath
☐ Bronchitis ☐ Wheezing
☐ COPD ☐ Other respiratory issues: _____

☐ **Cancer**
Type: _____ Date Diagnosed: _____
Current Treatment: _____
Current Oncologist: _____ Last Exam: _____

☐ **Neurologic Disorder**
☐ Seizure ☐ Stroke (CVA) ☐ Change in Speech or Vision ☐ Fainting or Dizziness ☐ Headaches or Migraines

Patient Name: _____ SSN: _____
(last name) (first name) (initial)

☐ **Psychologic Disorders**
- ☐ Depression or Anxiety
- ☐ Bi-Polar Disorder
- ☐ Suicidal Thoughts
- ☐ Other Mental Illness _____

☐ **Musculoskeletal**
- ☐ Arthritis
- ☐ Back or Next Pain
- ☐ Joint Pain or Swelling Where: _____
- ☐ Rheumatoid Arthritis
- ☐ Muscle Pain or Weakness _____
- ☐ Fracture List any fractures including date: _____
- ☐ Osteoporosis or Osteopenia Date of last Bone Density test (DXA): _____

☐ **Gastrointestinal**
- ☐ Heartburn
- ☐ Jaundice
- ☐ Chronic Diarrhea or Constipation
- ☐ Stomach Ulcer
- ☐ Abdominal Pain
- ☐ Gastric Reflux
- ☐ Dysphagia (Trouble Swallowing)
- ☐ Diarrhea / Loose Stool
- ☐ Hepatitis What kind: _____ First diagnosed? _____

☐ **Fatigue**
- ☐ Lumps or Masses
- ☐ Epilepsy
- ☐ Lupus or other Autoimmune Disorder
- ☐ Blood in Stool
- ☐ Aids / HIV
- ☐ Alcoholism
- ☐ Thyroid Disorder
- ☐ Irregular Periods Last Period: _____

☐ **Other Conditions**
- ☐ Weight Changes
- ☐ Anemia
- ☐ Hair Loss
- ☐ Excessive Thirst, Hunger or Urination
- ☐ Bruising
- ☐ Heat or Cold Intolerance

IMMUNIZATIONS *(indicate year of last vaccination)*

Tetanus _____ *(recommended every 10 years)*

Pneumonia _____ *(recommended every 5 years for age 50 and older but no more than 2 per lifetime)*

Hepatitis A _____ Hepatitis B _____

Influenza _____ Meningococcal _____

PREVENTATIVE EXAMS *(indicate year of last exam)*

Colonoscopy _____	Mammography _____	Cholesterol _____
PSA _____	Pap Smear / Gyn _____	Carotid Doppler _____
Eye Exam _____	Stress Test _____	TB Test _____
EKG _____	Rectal Exam _____	Chest X-Ray _____

FAMILY HISTORY

☐ Diabetes	Relationship: _____		Are they still alive? ☐ Y ☐ N
☐ Heart Disease	Relationship: _____		Are they still alive? ☐ Y ☐ N
☐ Stroke	Relationship: _____		Are they still alive? ☐ Y ☐ N
☐ Seizure Disorder	Relationship: _____		Are they still alive? ☐ Y ☐ N
☐ Mental Illness	Relationship: _____		Are they still alive? ☐ Y ☐ N
☐ Other:	Relationship: _____		Are they still alive? ☐ Y ☐ N
☐ Cancer	Relationship: _____	Type: _____	Are they still alive? ☐ Y ☐ N

ADDITIONAL CONDITIONS

☐ Dry Eyes	☐ Insomnia	☐ Kidney Disease	☐ Hot Flashes	☐ Hearing Problems
☐ Dry Mouth	☐ Mouth Ulcers	☐ Blood in Urine	☐ Cold Intolerance	☐ Ear Pain
☐ Hoarseness	☐ Muscle Weakness	☐ Bed Wetting	☐ Heat Intolerance	☐ Sinus Problems
☐ Visual Changes	☐ Nausea / Vomitting	☐ Painful Urination	☐ Night Sweats	☐ Swollen Glands
☐ Excessive Cough	☐ Internal Bleeding	☐ Lack of Bladder Control	☐ Fever / Chills	

☐ Fingertips turn colors (blue, red, white) when cold

☐ Develop a rash when exposed to sunlight ☐ Rashes / Nodules Where _____

☐ Ever experienced a painful eye

AUTHORIZATION FOR CONSENT OF CONFIDENTIAL INFORMATION

Patient Name: _____ DOB: _____
(last name) (first name) (initial)

Mailing Address: _____
(street/p.o. box) (city) (state) (zip code)

By my signature below, I give my authorization to discuss my protected health information (PHI), including results of laboratory tests, radiology imaging results, and/or other test results to the following designated representative(s):

Patient Initials

_____ My Spouse Name: _____

_____ My Child/Children Name(s): _____

_____ Other Designee Name(s): _____

_____ Personal Representative Name(s): _____

_____ Messages may be left on my answering machine/voicemail at **home**. Phone: _____

_____ Messages may be left on my answering machine/voicemail at **work**. Phone: _____

_____ Message may be left on my cell phone voicemail. Phone: _____

_____ DO NOT SHARE MY PROTECTED HEALTH INFORMATION WITH ANYONE OTHER THAN MYSELF.

_____ _____
Patient Signature Date Signed

_____ _____
Witness Date Signed

This authorization shall be valid for one (1) year from the date of signature, unless revoked in writing by the patient prior to that expiration. As a patient, you have a right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Woodlands Diagnostic Clinic must receive the revocation in writing. The revocation must include 1) the patient's name, address, and date of birth, 2) patient's desire to revoke the authorization, 3) the date of the revocation and 4) the patient's signature. All revocations must be sent in writing to the attention of Woodlands Diagnostic Clinic's Privacy Officer at 9201 Cypress Station Drive, Suite 200, Shenandoah, TX 77380 ATTN: Medical Records or may be emailed to records@woodlandsdiagnostics.com. If faxed or mailed, the revocation will not be considered effective until received and processed by the Privacy Officer.

ELECTRONIC PRESCRIPTIONS AND PRESCRIPTION REFILL POLICY

In an effort to better serve your needs, Woodlands Diagnostic Clinic has the capability to send your prescriptions by electronic transmission directly to your pharmacy. Please provide your pharmacy information to accommodate any future prescription delivery:

Patient Name: _____ DOB: _____
(last name) (first name) (initial)

Pharmacy Name: _____ Phone Number: _____

Mailing Address: _____
(street/p.o. box) (city) (state) (zip code)

Prescription refill requests made outside of an office visit, whether called into, faxed or mailed to a pharmacy, provider or mail order service, are done so under the following cost structure:

1 to 3 prescriptions	**$15**
4 to 6 prescriptions	**$25**
Over 7 prescriptions	**$35**
Triplicate Rewrite	**$50**

Prescriptions for non-narcotic medications are sent electronically to the pharmacy of your choice, as listed above.

Prescriptions for controlled medications requiring an Office Prescription Form (or triplicate) require a 24-hour notice; 48-hours if an alternate pickup location is requested.

Please allow a two-week advance notice for prescription refills. You can use our patient portal or your local pharmacy to send a notice to our office. Regardless of communication method, any prescription refill requests made outside of an office visit are done so under the cost structure listed above.

Any form you bring to WDC that needs to be filled out by a physician requires a payment of a $25 Form Fee. Please allow three business days for any form completion, which is payable at the time of pick up.

It is our wish to provide you the best possible service by streamlining our processes. Thank you for your continued use of our services.