Roman Family Practice, PLLC PATIENT REGISTRATION FORM

Please complete ALL fields in print. ***How did you hear about us**? _____

PATIENT INFORMATION			
Name: LAST FIRST M.I.			**Gender** Male ☐ Female ☐
Date of Birth:	**Patient Email:**		
Address:	**City**:	**State**:	**Zip Code**:
Phone Number ( ) -	**Social Security Number:**		
Current Insurance?	**Has insurance changed recently? Y / N (please circle one, if yes complete requested insurance information below)**		
PRIMARY INSURANCE & SUBSCRIBER INFORMATION			
Primary Insurance Name:	**Relationship to Subscriber:**		
Subscriber's Name: LAST FIRST M.I.	**Subscriber's Date of Birth** / /		
Subscriber ID #	**Group #**	**Plan #**	**Pharmacy #**
SECONDARY INSURANCE			
Secondary Insurance Name:	**Relationship to Subscriber:**		
Subscriber's Name: LAST FIRST M.I.	**Subscriber's Date of Birth** / /		
Subscriber ID #	**Group #**	**Plan #**	**Pharmacy #**
EMERGENCY CONTACT AND RELEASE OF INFORMATION			
Emergency Contact:	**Relationship to Patient:**	Phone No.:	
*****If patient is a child, who may authorize treatment for this child?	*****Relationship to Patient:	Phone No.: ( ) -	
Do you have a telephone answering machine or voicemail in your home?	Yes ☐	No ☐	
If so, may we leave messages from this office on that machine?	Yes ☐	No ☐	
Do you authorize release of your medical information to anyone besides your insurance carrier(s)? If so, whom?	Yes ☐	No ☐	

I authorize Roman Family Practice, PLLC, or its representative, to release to my insurance company or its representative any records or diagnostics information of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Tricare, private insurance, and any other health plan to Roman Family Practice, PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not paid by said insurance. An authorized signature is on file below. By signing, I attest that all information provided is true and complete and that my injury/illness is not work related. The responsible party is billed for appointments unkept or cancelled with less than 48 hours' notice. I understand that I will be assessed the bank charge for each check returned due to insufficient funds. In the event of default, I (We) promise to pay legal interest on the debt, together with such collection costs and reasonable attorney fees as may be required to affect collection of this note. I hereby authorize Roman Family Practice, PLLC to release all information necessary to secure payment and treatment.

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** All co-pays are due at time of service.

_____ _____

Patient, Parent or Guardian's Signature **Date**

Cecilia Roman, FNP

2030 Heights Dr. Ste 3 Harker Heights, TX 76548

Phone: (254)833-5023 Fax: (254)554-8479

Authorization for Release of Information:

I hereby authorize the following information to be released form the medical record of:

Patient Name:_____Date of Birth:_____

Social Security Number:_____

This Information needs to be Released:

To:___Cecilia T. Roman, FNP From:_____

___2030 Heights Dr. Ste 3 _____

___Harker Heights, TX 76548 _____

Please Check Information to be Released:

___Progress Noted	___MRI Report	___Pathology Report
___Lab report	___History & Physical	___Emergency Rm. Report
___X-Ray Report	___Operative Report	___Other

I understand that, to the extent any recipient of this information, as identified above, is not a "covered entity" under Federal of Texas Privacy laws, the information may no longer be protected by Federal or Texas laws once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.

I understand that I may revoke this authorization in writing at any time, except to the extent that the clinic of Cecilia Roman, FNP, has already relied on this authorization.I understand that I may revoke this authorization by providing a written request for revocation stating my intent to revoke this authorization.

I understand that Cecilia Roman, FNP, may not condition treatment on my completion of this authorization form.

If information is being released directly to me by the clinic of Cecilia Roman, FNP, I understand that my medical record contains reports, test results, and notes that only the Provider can interpret. I have been advised that I should contact my Provider regarding any misunderstanding of entries in my medical records. I will not hold liable the clinic of Roman Family Practice, PLLC, or Cecilia Roman, FNP, for any misinterpretation of the information in my record as a result of not consulting my Provider for the correct interpretation. This authorization will expire in 180 days or at the date or event specified here:_____.

I understand that the information released for the specific purposed stated above and may not be provided in whole or in part to any other agency, organization, or person.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Representatives Authority to act for Patient Witness

ROMAN
FAMILY PRACTICE

Office Policies and Procedures

1. There will be a $40.00 no show fee charged to the patient for each missed appointment.

2. If you do not show up for your appointment on 3 consecutive occasions, you will be notified of your discharge as a patient of our clinic and you will be given 30 days to find a different provider.

3. There is a fee for printed medical records starting at $30.00. However, if your records are requested by a physician involved in your care, this fee does not apply. These records will be mailed or faxed to the requesting provider.

4. There is a will be a fee for patients request to complete any letter, paperwork, or documents, starting at $30.00. Please allow 7-10 business days for completion.

5. There is a 24-48 hour turn around period for all prescriptions to be picked up or called into the pharmacy of your choice.

6. All co-pays are due at check-in and before being seen by medical care professionals at Roman Family Practice. Please note that any additional fees, other than copays, are also due upon check-in.

7. Any check returned to our office will result in our acceptance of cash-only payments for services going forward.

I have read and understood the above policies and procedures for Roman Family Practice.

_____ _____

Patient Name (print) Patient Signature

_____ _____

Responsible Party's Name (print) Responsible Party's Signature

Provider Name and Address

Roman Family Practice, PLLC
3106 S. WS Young Dr.
Suite B-203
Killeen, TX 76542-2000

ROMAN
FAMILY PRACTICE

Patient Name

Policy Number

Insurance Non-Covered Release

To the patient: Insurance companies will only pay for services that are determined to be reasonable and necessary under the insurance policy. If your insurance company determines that a particular service, that would otherwise be covered, is not reasonable and necessary under its policy standards, your insurance will deny payment for that service. As your provider, I feel that the service(s) listed bellow are in your medical interest. I believe that, in your case, your insurance is likely to deny payment for the reason stated below.

I have been notified by my Provider that he/she believes that, in my case, ***the insurance company is likely to deny payment for the services(s) identified below*** *for the reason(s) stated. If the insurance company denies payment, I agree to be personally and fully responsible for the payment of said services.*

Patient Name (print)	Patient Signature	Date
Responsible Party's Name (print)	Responsible Party's Signature	Date

Date	Service	Reason	Charge	Pt. Initials
Date	Service	Reason	Charge	Pt. Initials
Date	Service	Reason	Charge	Pt. Initials

1. Your insurance does not usually pay for this many visits or treatment.
2. Your insurance usually does not pay for this service.
3. Your insurance usually pays for only one nursing home visit per month.
4. Your insurance usually does not pay for this shot.
5. Your insurance usually does not pay for this many shots.
6. Your insurance does not pay for this because it is a treatment that has yet to be proven effective.
7. Your insurance does not pay for this office visit unless it was needed because of an emergency.
8. Your insurance usually does not pay for like services by more than one doctor during the same time period.
9. Your insurance usually does not pay for this many services within this time period.
10. Your insurance usually does not pay for more than one visit a day.
11. Your insurance usually does not pay for such an extensive procedure.
12. Your insurance usually does not pay for like services by more than one doctor for the same or similar specialty.
13. Your insurance usually does not pay for this equipment.
14. Your insurance usually does not pay for this lab test.

CIRCLE ONE: MEDICAID MEDICARE P.C.A TRI-CARE/FOUNDATION HEALTH OTHER

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name*(Last, First, M.I.):* ☐ M☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No

Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes –pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No
	If yes, are you trying for a pregnancy?			☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:				
	Any discomfort with intercourse?			☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?			☐ Yes	☐ No
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?			☐ Yes	☐ No
	Would you like information on the preparation of these?			☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?			☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	