Dear New Patient,

We have enclosed your new patient paperwork with this letter. Please fill out the forms completely. The paperwork may be returned in person, by mail or fax to:

823 Junction Highway
Kerrville, Texas 78028
Phone: (830) 258-7900
Fax: (830) 258-7820

On the day of your appointment, please bring:

- Your insurance cards and photo identification (driver's license preferred).
- All Medicines you are taking; including over-the-counter medicines and supplements, in their original packaging.
- If you use mail-in prescription service please bring your drug formulary list that shows which medicines they pay for.
- Please arrive at least 30 minutes early for check in process.

If you have any questions, please call us Monday-Friday 7am-5pm at 830-258-7900.

Thank you for choosing Peterson Community Care as your healthcare provider. We look forward to serving you.

Sincerely,

Peterson Community Care

PATIENT REGISTRATION FORM

PETERSON HEALTH

PATIENT INFORMATION (Please print)			
Patient Name (last, first, MI):	Gender: M F	Date of Birth (MM/DD/YY):	Social Security Number:
Mailing Address:		Home Phone (Primary Y/N):	Work Phone:
City: State: Zip:		Cell Ph #/Pager (Primary Y/N):	Ok to receive text message reminders? Y or N
Ethnicity/Race:	Marital Status:	Maiden Name:	Driver's License #:
Employment Status: (Circle One) Employed Full-Time Student Part-Time Student Retired		Primary Care Doctor:	
Patient's Employer and Occupation:		Preferred Local Pharmacy:	
Employer's Address:		Preferred Mail-In Pharmacy:	

RESPONSIBLE PARTY INFORMATION			
Name:		Relationship to Patient:	
Address:		Employer & Telephone Number:	
Home Phone:	Cell Phone:	Social Security Number:	Date of Birth:

INSURANCE INFORMATION		
Primary Insurance Name:		
Policy Holder:	Insured's Date of Birth:	Insured's SSN:
Insured Employer's Name:	Policy #:	Group #:
Secondary Insurance Name:		
Policy Holder:	Insured's Date of Birth:	Insured's SSN:
Insured Employer's Name:	Policy #:	Group #:
If you are over 65 years old and Medicare is your secondary policy, please list reason:		

EMERGENCY CONTACT INFORMATION		
First Contact Name:	Phone:	Relationship:
Second Contact Name:	Phone:	Relationship:

CONSENT TO TREAT

I give permission for Peterson Health to render to me (and/or my named dependent above) medical treatment. I also understand I have the right to refuse any procedure or treatment and to discuss all medical treatments with my provider.

ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to Health for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine the benefits payable for related and/or provided services. I understand that I must pay my share of the costs, including co-pays and deductibles at each visit. Furthermore, if my insurance does not pay or I do not have insurance, I must pay for the cost of these services.

Patient Signature for Consent to Treat and Assignment of Benefits	Signature of Patient Representative (if patient unable to sign)	
Date Signed	Date Signed	
	Relationship to Patient:	Reason Patient Unable to Sign:

PATIENT HIPAA
ACKNOWLEDGEMENT/DISCLOSURE

PETERSON HEALTH

I understand Congress passed a law entitled the Health Insurance Portability and Accountability Act ("HIPAA") that limits disclosure of my protected health information ("PHI"). This authorization is being signed because it is crucial that my medical providers readily give my protected medical information to the person(s) designated below in order to allow me the advantage of being able to discuss and obtain advice from my family and/or friends.

Therefore, pursuant to 45 CFR 164.501(a)(1)(iv) Peterson Health, a covered entity (being a healthcare provider as defined by HIPAA), is permitted to disclose protected health information pursuant to and in compliance with this valid authorization under 45 CFR §164.508.

I,_____ , hereby authorize Peterson Health to disclose the following information:
(PRINT NAME)

All health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of healthcare providers, whether past, present or future, and any other information which is in any way related to my healthcare. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person(s) or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give full authorization to ANY protected medical information to the person(s) named in this authorization.

By signing this authorization, I acknowledge that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the person(s) whose name(s) are written below, and the information, once disclosed, will no longer be protected by the rules created in HIPAA.

This authorization shall remain in effect until my WRITTEN MODIFICATION and/or REVOCATION is received by Peterson Health.

AUTHORIZED INDIVIDUALS TO RECEIVE MY PROTECTED HEALTH INFORMATION (PHI)				
1ST Contact: Last Name:		First Name:	Relationship:	
Home Phone:	Cell Phone	Work Phone:	Other Phone:	Gender:
2nd Contact: Last Name:		First Name:	Relationship:	
Home Phone:	Cell Phone	Work Phone:	Other Phone:	Gender:
3rd Contact: Last Name:		First Name:	Relationship:	
Home Phone:	Cell Phone	Work Phone:	Other Phone:	Gender:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES		
Your name and signature below indicate that you received a copy of Peterson Health's Notice of Privacy Practices, on the date indicated below. If you have any questions regarding the information set forth in the Notice of Privacy Practices, please do not hesitate to contact the Privacy Officer at (830)258-7536.		
Printed Name of Patient:	Signature of Patient:	Date Signed:
Signature of Patient's Representative:	Relationship to Patient:	Reason Patient Unable to Sign:

PETERSON HEALTH

Medical History Form

Name: _____ DOB:_____ Date: _____

Reason for today's Visit: _____

Past Medical History (Please check if applicable)			
Condition/Disease	Year	Condition/ Disease	Year
☐ High blood pressure		☐ Liver Disease	
☐ High Cholesterol		☐ Kidney disease	
☐ Heart Attack		☐ Cancer	
☐ Heart Failure		☐ Arthritis/Pain in Joints	
☐ Diabetes		☐ Thyroid issues (high / Low)	
☐ Stroke		☐ Ulcers	
☐ Acid Reflux/GERD		☐ COPD/ Asthma	
☐ Depression/Anxiety		☐ Seizures	
☐ Bipolar/Schizophrenia		☐ Other:	

Past Surgical History (Please check if applicable)			
Condition/Disease	Year	Condition/ Disease	Year
☐ Heart		☐ Back or spine	
☐ Lung		☐ Tonsils	
☐ Gall Bladder		☐ Prostate	
☐ Appendix		☐ Other:	
☐ Hysterectomy			

Social History
Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated
Are you currently Pregnant ☐ Yes ☐ No # of Children: Ages:
Work Status ☐ Employed Full-Time ☐ Unemployed ☐ Disabled
Highest Level of Education
Do you exercise ☐ Yes ☐ No How often (if yes):
Alcohol use ☐ Yes ☐ No Type: Freq:
Tobacco use ☐ Yes ☐ No Type: Per day:
Recreational drug use ☐ Yes ☐ No Type: Freq:
Currently sexually active ☐ Yes ☐ No History of STDs: ☐ Yes ☐ No
Do you have prescription coverage ☐ Yes ☐ No Can you afford medications ☐ Yes ☐ No

PETERSON HEALTH

Name: _____ DOB:_____ Date: _____

Family History			
Relative	Living / Deceased	Current Age or Age at Death	Health Conditions
Father			
Mother			
Brother			
Sister			
Other:			

Review of Symptoms (Please check if applicable)			
☐ Fever or Chills	☐ Lump in breast	☐ Blood in urine	☐ Anxiety
☐ Vision problems	☐ Breast discharge	☐ Incontinence	☐ Difficulty sleeping
☐ Hearing Problems	☐ Trouble swallowing	☐ Easy bruising	☐ Depression
☐ Nosebleeds	☐ Nausea / Vomiting	☐ Pain in legs	☐ Skin lesion/skin rash
☐ Sore Throat	☐ Stomach pain	☐ Joint pain	☐ Numbness/Tingling in extremities
☐ Lump in neck	☐ Yellow Skin	☐ Unexpected weight loss/gain	Other:
☐ Tooth problems	☐ Diarrhea	☐ Heat/cold intolerance	
☐ Cough	☐ Constipation	☐ Fatigue	
☐ Wheezing	☐ Black or bloody stool	☐ Night Sweats	
☐ Chest discomfort	☐ Excessive thirst	☐ Passing out	
☐ Shortness of breath	☐ Excessive hunger	☐ Tremors	
☐ High/low blood sugar	☐ Frequent urination	☐ Headache	

Disease Prevention & Health Maintenance			
	Date/Year		Date/Year
Flu Vaccine		Pap Smear	
Pneumonia Vaccine		Mammogram	
Shingles Vaccine		Bone Density Test	
COVID-19 Vaccine		Eye Exam	
Prostate Exam		Dental Exam	

PETERSON HEALTH

Name: _____ DOB:_____ Date: _____

Other Healthcare Providers		
Specialty	Provider Name	Date Last Seen
Pulmonologist (Lungs)		
Cardiologist (Heart)		
Endocrinologist		
Dermatologist (Skin)		
Nephrologist/Urologist (Kidney/Bladder/Urinary)		
Eye Doctor		
Medical Equipment Company		
Pharmacy		
Other:		

Current Medications		
Medication Name	Dose (mg/mcg/units)	How many times a day?

Allergies		
Medication Name / Food Item	Reaction	Severity (Low, Moderate, High)

Rev. 01/28/2021

PETERSON HEALTH

Peterson Community Care Clinic Polices and Guidelines Agreement

Welcome to Peterson Community Care Clinic. We are so glad that you have decided to become part of our practice. Our mission is to provide exceptional, compassionate, patient-centered care.

Appointment Day:

- Please arrive at least 30 minutes before your initial appointment time, and 15 minutes before your follow-up appointment time.
- Please bring all your medications (prescription and over the counter) in their original containers to the appointment for review.

Late Arrivals and Appointment Cancellation:

- In the event that you are more than 15 minutes late for your appointment you may be required to reschedule. We will try our best to work you back into the schedule if possible.
- We ask that you reschedule appointments **at least 24 hours** in advance if needed.
- Appointments that are cancelled on the day of the appointment may be counted as a no-show.
  - If you have 3 no-show appointments you may be dismissed from the practice.
  - You will receive a notification (by phone or in-writing) after each no-show appointment.

Lab Tests:

- If lab work has been ordered please complete one week prior to your appointment. Peterson Community Care will provide the orders for lab work when applicable.

Prescription Refills:

- Please contact your pharmacy first at least a week before refill is needed and they will send a refill request to the clinic.
- Please allow 2 business days for us to respond. Please contact clinic if no response within 2 business days.
- If you need emergent refill, please contact your provider's nurse.

Controlled Substances:

- We require an office visit for refills of controlled substances, for example narcotics (used for pain management), benzodiazepines (used for anxiety), etc. No Phone requests are allowed.
- Patients on controlled substances must be seen every 90 days or more frequently if needed by the provider.
- You cannot request a refill sooner on these medications unless specifically approved by your provider.
- We will request you to sign a patient/provider agreement when we manage these medications.

After Hours (5:00pm to 7:00am), Weekends, and Holidays: You may reach the ON-CALL Provider by calling our office at **830-258-7900** and following instructions on recorded message.

I have read and understand the above office policies and agree to abide by them.

_____ _____

Signature Date

Rev. 02/03/2021