COLLEGE PARK MEDICINE
17191 St. Luke's Way, Suite 200
The Woodlands, TX 77384
936-271-2555

Workers' Compensation Registration

PATIENT NAME_____ **DATE OF BIRTH**_____ **SEX M F**

ADDRESS_____

CITY_____ **STATE**_____**ZIP**_____ **DRIVER'S LICENSE #**_____

PRIMARY PHONE #_____ **SECONDARY PHONE #**_____

EMAIL _____

EMPLOYER_____ **WORK PHONE**_____

NAME OF WORK COMP INSURANCE _____

DATE OF INJURY_____ **CLAIM/CASE #**_____

SOCIAL SECURITY #_____

(Due to changes in insurance processing the above information is necessary to file claims)

Pharmacy must be listed!!! ↓

PHARMACY NAME_____ **PHARMACY PHONE**_____
PHARMACY ADDRESSS/INTERSECTION_____

PERSON TO NOTIFY IN CASE OF EMERGENCY _____
RELATIONSHIP_____ **PHONE#**_____

Initials: _____ **No Show Fee:** We reserve an appointment slot just for you. If you need to cancel or reschedule, please notify the office 24 hours prior to your appointment time to avoid a $50 no show fee.

I hereby authorize COLLEGE PARK MEDICINE, P.A. to furnish information to insurance carriers concerning my illness and treatments. I hereby assign COLLEGE PARK MEDICINE, P.A. all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. Furthermore, I give consent to be treated by the physicians/staff at COLLEGE PARK MEDICINE, P.A.

SIGNATURE: _____**DATE**_____

**********To Our Patients: Our goal is to provide quality medical services for our patients. We will strive to direct your care and your need for specialist consults, lab work, and other test according to your managed care guidelines. However, our office deals with many different plans, and it is the patient's responsibility to make sure that all facilities and specialists that we recommend you to are on your health care plan. Please verify their participation **BEFORE** services rendered to receive network benefits from your insurance company. **********

HEALTH HISTORY

NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: ____/____/_____

Have you ever had any of the following? Please check all that apply.

	Self	Mother	Father	Sibling
Diabetes				
High Cholesterol				
High Blood Pressure				
Heart Trouble				
Stroke				
Kidney or Urinary Disorder				
Bowel GI Disorder				
Bleeding or Blood Disorder				
Asthma or Emphysema				
Cancer				
Glaucoma or Eye Problems				
Neurological Disorder				
Mental Illness				
Thyroid Problem				
Sexually Transmitted Disease				
Hepatitis or Yellow Jaundice				
Infectious Disease				
Sleep Apnea				
Other:				
Other:				

HOSPITALIZATIONS OR SURGERIES **YEAR**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

LIST CURRENT MEDICATIONS & DOSE

_____
_____
_____
_____
_____
_____

LIST DRUG ALLERGIES

_____
_____
_____

Do you smoke or use oral tobacco? YES NO
How often? _____
For how many years? _____

Do you drink alcohol? YES NO
How often? _____
For how many years? _____

Have you ever experimented with drugs?
YES NO

FOR WOMEN ONLY

Are you pregnant? YES NO
Last menstrual cycle: _____
Number of pregnancies: _____
Last pap smear: _____
Last mammogram: _____

DR. SIGNATURE _____

Due to updated guidelines per Insurance plans

Please choose one of the following:

RACE: (circle one)

American Indian or Alaskan Native
Asian
Native Hawaiian or Other Pacific
Black or African American
White
Hispanic
Other Race
Other Pacific Islander
Unreported/Refused to Report

ETHNICITY: (circle one)

Hispanic or Latino
Not Hispanic
Refused to Report

LANGUAGE:

English
Other
Indian
Spanish
Russian

RELEASE OF MEDICAL RECORDS FOR HEALTH CARE BENEFITS

I _____, hereby authorize and give permission to all healthcare providers, who have rendered medical care or related services to me, to give to my employer _____(or representative with written authorization of the same) complete access to all of the medical records related to my injury, and/or any previous conditions that predisposed me to this injury, and all financial information pertaining to any diagnosis, treatment, condition or prognosis with my employer. This release is given for the purpose of the evaluation and treatment of my alleged injury during my employment at _____.

A copy of this release shall be as valid as the original.

Date: _____

_____

Employee Signature

_____

Printed Name of Employee

_____

Witness Signature

_____

Printed Name of Witness

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E-PRESCRIBING CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe Program.

1. **FORMULARY AND BENEFIT TRANSACTIONS**- Give the prescriber information about which drugs are covered by the drug benefit plan.
2. **MEDICATION HISTORY TRANSACTIONS**- Provides the physician with the information about medications the patient is already taking to minimize the number of adverse drug events.
3. **FILL STATUS NOTIFICATION**- Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that **COLLEGE PARK MEDICINE** can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to **COLLEGE PARK MEDICINE** to enroll me in the E-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name: _____ Date of Birth: _____

Signature of Patient/Guardian: _____

Today's Date: _____ *If Guardian signed, Relationship to Patient: _____

Health Disclosure Information

I, _____ will allow College Park Medicine to disclose information to the following person(s) about my health, if I am not available. Acknowledgement of review of Notice of Privacy Practices

I understand the Notice of Privacy Practice is displayed in the office for my reference but I can be offered a copy to review of College Park Medicine, P.A.'s Notice of Privacy Practices, which explains how my medical information will be used and disclosed. Please ask for your copy at time of check in if desired.

Name:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Can we leave a message to your voice mail? _____ Yes _____ No

If yes, at what number(s)? _____ (I understand I am the only person who can get this message)

Leave message only for the following:

____ Appointment Reminder _____ Response to your Voicemail

____ Normal Lab Results _____ Referrals/Testing Schedule

_____ _____

Signature of Patient or Personal Representative Date

UPDATED 4/16/14