Patient Registration Form

Patient Information

Patient Information			
Last Name:	First Name:	M.I.	Previous Name (if applicable)
Mailing Address:			Apt #
City/State/Zip:			
Home Phone:	Cell Phone:		Work Phone:
Preferred Method of Contact (Please Select Only One): ☐Voice ☐Text	If Voice, Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work		If Voice, would you be okay with patient information in voicemail: ☐Yes ☐No
Sex (Biological Gender): ☐ Male ☐ Female	Date of Birth:		Family Physician or Pediatrician:
Marital Status:	Employer Name:		Social Security #:
Emergency Contact Name:	Relationship to Patient:		Emergency Contact Phone #:

Additional Information and Responsible Party

Additional Information **(PLEASE FILL OUT ALL SECTIONS BELOW)**

Email Address:

Can we leave a message regarding your medical care & test results?
o Yes o No

Race (please select one or multiple):
- o White
- o American Indian or Alaska Native
- o Asian
- o Black or African American
- o Chinese
- o Decline to specify
- o Filipino
- o Guamanian or Chamorro
- o Japanese
- o Korean
- o Native Hawaiian or Pacific Islander
- o Other Asian
- o Other Race
- o Samoan
- o Vietnamese
- o White

Ethnicity (please select one):
- o Hispanic or Latino
- o Chicano
- o Spanish
- o Not Hispanic or Latino
- o Decline to Specify
- o Cuban
- o Mexican
- o Mexican American
- o Puerto Rican
- o Other
- o Unknown

Preferred Language (please select one): o English o Spanish o Hindi/Urdu o Sign Language o Vietnamese o Mandarin/Cantonese o Other ________________

Preferred Pharmacy Name & Location:

Responsible Party – If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor.

Last Name:		First Name:
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:		Relationship to Patient:

Insurance Information

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder Member ID:	Policy Holder Member ID:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I certify that I have read and agree to AccessHealth's payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to AccessHealth all money to which I am entitled for medical expenses related to the services performed from time to time by AccessHealth, but not to exceed my indebtedness to AccessHealth. I authorize AccessHealth to release any medical information to my insurance carrier or third party payer to facilitate processing of my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. I choose to receive communications from AccessHealth by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to AccessHealth. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Responsible Party: X____ **Date:** ____________

Printed Name of Responsible Party: X____ **Date:** ____________

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Household Information

Total Monthly Household Gross Income: $ ____________________ **Total People in Household:** __________

Student: ☐ Full-Time ☐ Part-Time ☐ Not in School

What is the highest level of school that you have finished? ☐ Less than high school degree ☐ High school diploma or GED ☐ Some College or more

What is your current work situation? ☐ Full-Time Job ☐ Part-Time Job ☐ Part-Time Job but looking for Full-Time Job ☐ Unemployed and looking for work ☐ Unemployed but not looking for work

Agriculture Status: ☐ Migrant Worker ☐ Seasonal Worker ☐ Not an Agriculture Worker

Are you a US Military Veteran: ☐ Yes ☐ No

Housing Status

(Please check only ***ONE*** box in the table below to indicate your current living situation. If you check under Unknown or Other, please write down in the blank spot what your living situation is.)

Self	Spouse	Family or Friends	Homeless Shelter	Street	Transitional	Unknown __________	Other ___________

Is your housing situation stable or unstable? ☐ Stable ☐ Unstable

Sexual Orientation / Gender Identity

Do you think of yourself as: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Not sure ☐ Other _____________

What is your current gender identity? *(mark all that apply)*

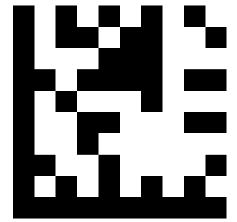
☐ Male ☐ Female ☐ Genderqueer, neither exclusively male nor female

☐ Transgender male / Trans-man / Female-to-male ☐ Transgender female / Trans-woman / Male-to-female

☐ Decline to answer ☐ Additional gender category/ other (please specify): ____

EACH MEMBER OF YOUR HOUSEHOLD WHO WILL BE A PATIENT OF ACCESSHEALTH MUST COMPLETE THIS FORM.

IMMUNIZATION REGISTRY (ImmTrac2)
ADULT CONSENT FORM



(Please print clearly)

Last Name

First Name **Middle Name**

Date of Birth / / **Gender:** ☐ **Male** ☐ **Female**

Address **Apartment #** **Telephone** - -

City **State** **Zip Code** **County**

Mother's First Name **Mother's Maiden Name**

ImmTrac2, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates immunization records for public health purposes (e.g., giving all doctors treating a patient a central place to see that patient's immunization records). With your consent, your immunization information will be included in ImmTrac2. *For a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation for that minor by completing the ImmTrac2 Minor Consent Form (# C-7). The ImmTrac2 Minor Consent Form (# C-7) can be downloaded by visiting www.ImmTrac.com.*

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration and Release of Immunization Records to Authorized Persons / Entities

I understand that, by granting the consent below, I am authorizing release of my immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry, ImmTrac2. Once in ImmTrac2, my immunization information may by law be accessed by:

- a Texas physician, or other health care provider legally authorized to administer vaccines, for treatment of the individual as a patient;
- a Texas school in which the individual is enrolled;
- a Texas public health district or local health department, for public health purposes within their areas of jurisdiction;
- a state agency having legal custody of the individual;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy.

I understand that I may withdraw this consent at any time.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my information in the Texas immunization registry.

Individual (or individual's legally authorized representative):

Printed Name ____________________

Date ____________ Signature ____________________

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.texas.gov for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com

Texas Department of State Health Services • ImmTrac Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in ImmTrac2 and **affirm** that consent has been granted. **DO NOT fax to ImmTrac2. Retain this form in your client's record.**

TEXAS Health and Human Services | Texas Department of State Health Services

Adult Safety Net (ASN) Program

ADULT ELIGIBILITY SCREENING RECORD

PURPOSE: To determine and record eligibility for the DSHS ASN Program. A record of the eligibility status of adults receiving vaccine supplied by DSHS must be maintained either in hard copy by the clinic providing the service or in an electronic system such as TWICES. Hard copies must be maintained for five (5) years. ASN eligibility screening and documentation of eligibility status must take place at each immunization visit to ensure eligibility status for the program.

Date of Screening: ______/______/______ (mm/dd/yy)

Name: ____
(Last) (First) (Middle initial)

Date of Birth: ______/______/______ (mm/dd/yy) **Gender:** ☐ Male ☐ Female **Veteran:** ☐ Yes ☐ No

Important Information for Former Military Service Members

Women and men who served in any branch of the United States Armed Forces, including Army, Navy, Marines, Air Force, Coast Guard, Reserves or National Guard may be eligible for additional benefits and services. For more information, please visit the Texas Veterans Portal at www.veterans.portal.texas.gov.

Eligibility Criteria:

☐ I declare that I qualify for vaccines through the ASN Program because I do not have health insurance.

☐ I am 19 years of age and I have been referred to finish a vaccine series that I began when I was 18 years of age or younger and eligible under the Texas Vaccines for Children (TVFC) Program. This option is only available as long as I have not reached my 20th birthday. "Vaccine series" applies to Hepatitis A, Hepatitis B, Human Papillomavirus (HPV), Mumps, Measles, & Rubella (MMR), Varicella, and Meningococcal vaccines.

Referring Provider: ____

Patient Signature:________________________________ **Date:** ______/______/______ (mm/dd/yy)

NOTE: Knowingly falsifying information on this document constitutes fraud. By signing this form, I hereby attest that the above information is true and correct. I declare that the person named above is eligible to receive ASN vaccines.

With few exceptions, you have the right to request and to be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the agency to correct any information that is determined to be incorrect. See http://www.dshs.texas.gov for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, and 559.004)

Welcome to Your Medical Home

MAKE EACH DOCTOR'S VISIT WORK FOR YOU!

Before your visit

- Write your own questions and worries. Do not worry if it's a long list.
- If you see a specialist, **ask them to send their report to your primary provider here at AccessHealth**.
- **Confirm that your registration with AccessHealth is up to date.**

On the day of your visit

- Provide us with your complete medical history and information from any another medical provider.
- **Put all your medicines in a bag and bring them with you to your doctor's visit.**
- **Bring your Medicare, Medicaid, or other insurance card.** Bring your list of questions.
- Please ask for help, ask a friend or family member to join you.

During your visit

- Relax! Ask questions! Tell us when you don't understand. Remember we want the very best for you.
- Ask us to tell you the values of your blood pressure, weight, and lab tests. Keep a record of these.
- Ask us when you should schedule your next visit.

After your visit

- Keep your medical information in one place-ready for the next visit.

Things that you can do for your self

- Learn as much as you can about how to care for your illness. The more that you know, the better will be your health.
- Some health problems such as diabetes require you to change how you are eating and living. Talk with your doctor, family and friends as to how you can make these changes. Start enjoying the benefits of better health now.
- Make sure that you understand how to take your medicine. **If you do not understand how to take them, ask us for help.**
- Don't stop taking prescription medicine without first talking with your healthcare provider.

Call 24 Hours a Day, 7 Days a week

RICHMOND	STAFFORD	MISSOURI CITY	BROOKSHIRE	EAST FORT BEND
281-342-4530	**281-342-4530**	**281-342-4530**	**281-822-4235**	**281-342-4530**
400 Austin Street	10435 Greenbough Dr, Ste 300	307 Texas Parkway, Ste 100	531 FM 359 S	7707 Highway 6 South
Richmond, TX 77469	Stafford, TX 77477	Missouri City, TX 77489	Brookshire, TX 77423	Missouri City, TX 77459

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When to Choose the Hospital/Emergency Room or AccessHealth, Your Medical Home

We are fortunate in our community to have access to 24-hour Emergency Room care. Of course, no one can time an illness or injury to occur during the hours of a doctor's office or clinic. However, many acute illnesses, such as colds, flu, sprains, strains, minor infections, minor cuts and bruises, skin rashes, common diarrhea, lower back pain, mild vaginal infections, and irregular periods do not require an Emergency Room visit. Such ailments usually resolve on their own within a short period of time. If they require medical treatment, they should always be addressed at AccessHealth, your Medical Home. Generally, you should not go to the Emergency Room for medication refills, or medical problems that are chronic in nature, unless you experience sudden worsening of your condition. Always choose your Medical Home for check-ups, shots, and help with long term conditions.

So, when **should** one seek care at the Emergency Room? There are certain symptoms that should prompt an ER visit even during operating hours of AccessHealth. These include:

1. Severe chest pain
2. Vomiting Blood
3. Sudden loss of consciousness or change in mental status (acting strange)
4. Sudden weakness of body parts
5. Severe difficulty breathing
6. Overdose of medicine or ingestion of toxic substance. Call Poison Control at 1.800.222.1222
7. Severe burns or inhalation of smoke
8. Uncontrollable bleeding that will not stop
9. Attempted suicide
10. Emergency labor/ childbirth
11. Severe trauma (injury)
12. Sudden severe abdominal pain
13. Sudden severe headache or sudden loss of vision
14. New seizure (convulsion)

Sometimes it may not be clear when an illness is serious enough to use the Emergency Room. Children and older persons, or patients with underlying illness may need medical attention sooner than a young adult or otherwise healthy person. If you are not sure what to do and it is during AccessHealth office hours, you should call or come into the office. ***After hours you may call the office number*** and speak with the physician on-call about your illness.

It is important that you get proper care, and in a true emergency that means calling 911 or going to the Emergency Room; otherwise it means care at AccessHealth, your Medical Home. If you go to the Emergency Room, please schedule an appointment with AccessHealth within 10 days of your discharge.

Call 24 Hours A Day, 7 Days A Week

RICHMOND CENTER: 400 Austin St., Richmond, TX 77469
(281) 342-4530

ADULT CARE:
Monday – Friday: 7:00AM - 7:00PM; Saturday: 8:00AM - 12:00PM

PEDIATRIC CARE:
Monday, Tuesday, Thursday, Friday 7:00AM - 5:00PM; Wednesday: 7:30AM - 5:30PM; 2nd and 4th Saturday: 8:00AM - 12:00PM

STAFFORD CENTER: 10435 Greenbough Dr., Stafford, TX 77477
(281)342-4530

PEDIATRIC CARE: Monday – Thursday: 7:00AM - 7:00PM; Friday 7:00 AM – 4:00 PM; Saturday: 8:00AM - 12:00PM

DENTAL: Monday - Friday: 7:00AM - 7:00PM; Saturday: 8:00AM – 12:00PM

MISSOURI CITY CENTER: 307 Texas Parkway, Missouri City, TX 77489
(281)342-4530

ADULT CARE:
Monday, Tuesday, Thursday & Friday: 8:00AM - 6:00PM;
Wednesday: 7:00AM - 6:00PM

PEDIATRIC CARE:
Tuesday: 7:00AM – 7:00PM; Wednesday – Friday: 8:00AM – 5:00PM

EAST FORT BEND CENTER: 7707 Highway 6 South, Missouri City, TX 77459
(281) 342-4530

Monday – Friday: 8:00AM – 12:00PM

BROOKSHIRE CENTER: 533 FM 359 S., Brookshire, TX 77423 – (281) 822-4235

Monday – Thursday: 7:30AM – 5:30PM; Friday: 8:00AM – 5:00PM

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Información importante para antiguos miembros de las Fuerzas Armadas

Las mujeres y los hombres que hayan pertenecido a cualquier cuerpo de las Fuerzas Armadas de los Estados Unidos (incluidos el Ejército, la Armada, la Infantería de Marina, la Fuerza Aérea, la Guardia Costera, el cuerpo de reservistas o la Guardia Nacional) podrían recibir beneficios y servicios adicionales. Para más información, visite el Portal de Texas para Veteranos en https://veterans.portal.texas.gov.

Effective March 1, 2018 contractors are required to share this information with program applicants until further notice. For more information, visit program website.