

Patient Information			
First Name	Last Name	M.I.	Previous Name (if applicable)
Mailing Address		Apt Number	
City/State/Zip			
Home Phone	Cell Phone	Work Phone	
Preferred Method of Contact (Please Select Only One Option) <input type="checkbox"/> Voice <input type="checkbox"/> Text	If voice, please select preferred number for contact <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	If voice, would you be okay with patient information in voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Sex (Biological Gender) <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Family Physician or Pediatrician	
Marital Status	Employer Name	Social Security Number	
Emergency Contact Name	Relationship to Patient	Emergency Contact Phone Number	

Additional Information Please fill out all sections below	
Email Address	Can we leave a message regarding your medical care and test results? <input type="checkbox"/> Yes <input type="checkbox"/> No
Race (please select one or multiple) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Korean <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Unreported/Chose not to Disclose <input type="checkbox"/> Chinese <input type="checkbox"/> Other Asian <input type="checkbox"/> More than one race <input type="checkbox"/> Filipino <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan	Ethnicity (please select one) <input type="checkbox"/> Chicano <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Spaniard <input type="checkbox"/> Hispanic, Latino/a, or Spanish origin combined <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Mexican <input type="checkbox"/> Unknown <input type="checkbox"/> Mexican American <input type="checkbox"/> Decline to Specify <input type="checkbox"/> Other Hispanic, Latino/a, or Spanish Origin
Preferred Language (please select one) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Hindi or Urdu <input type="checkbox"/> Sign Language <input type="checkbox"/> Vietnamese <input type="checkbox"/> Mandarin or Cantonese <input type="checkbox"/> Other _____	
Preferred Pharmacy Name and 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.			
First Name	Last Name		
Date of Birth	Social Security Number	Phone	
Address of Person Responsible		Apt Number	
City/State/Zip	Relationship to Patient		

Primary Medical Insurance	Secondary Medical Insurance
Insurance Company Name	Insurance Company 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 Number	Policy Holder's Social Security Number
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.

PATIENT/GUARANTOR SIGNATURE	PRINTED NAME	DATE

Patient Information									
Total Monthly Household Gross Income (Please write)									
Total People in Household (Please circle) 1 2 3 4 5 6 7 8 Other _____									

Personal Status	
Are you a Student?	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Not in School
What is the highest level of school that you have finished?	<input type="checkbox"/> Less than high school degree <input type="checkbox"/> Some College or more <input type="checkbox"/> High school diploma or GED
What is your current work situation?	<input type="checkbox"/> Full-Time Job <input type="checkbox"/> Unemployed and looking for work <input type="checkbox"/> Part-Time Job <input type="checkbox"/> Unemployed, but not looking for work <input type="checkbox"/> Part-Time Job, but looking for Full-Time Job
Agriculture Worker Status	<input type="checkbox"/> Migrant Worker <input type="checkbox"/> Seasonal Worker <input type="checkbox"/> Not an Agriculture Worker
Are you a U.S. Military Veteran?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to disclose

Housing Status							
Please check only ONE box in the table below to indicate your current living situation.							
Self	Spouse	Family or Friends	Homeless Shelter	Street	Transitional	Unknown	Other
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
If you checked under Unknown or Other , please write down what your living situation is. _____							
Is your housing situation stable or unstable? <input type="checkbox"/> Stable <input type="checkbox"/> Unstable							

Sexual Orientation/Gender Identity	
Do you think of yourself as	<input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Not sure <input type="checkbox"/> Something else (please specify) _____
What is your current gender identity? (Mark all that apply)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Decline to answer <input type="checkbox"/> Transgender male/Trans-man/Female-to-male <input type="checkbox"/> Transgender female/Trans-woman/Male-to-female <input type="checkbox"/> Genderqueer, neither exclusively male nor female <input type="checkbox"/> Additional gender category/other (please specify) _____

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



(Please print clearly)

Grid for Last Name

Last Name

Grid for First Name

First Name

Grid for Date of Birth

Date of Birth

Grid for Address

Address

Grid for Middle Name

Middle Name

Gender: Male Female

Grid for Apartment #

Apartment #

Grid for Telephone

Telephone

Grid for City

City

Grid for State

State

Grid for Zip Code

Zip Code

Grid for County

County

Grid for Mother's First Name

Mother's First Name

Grid for Mother's Maiden 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.



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 is 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.

AccessHealth

Call 24 hours a day, 7 days a week

(281) 342-4530

Brookshire Clinic

533 FM 359 S. Brookshire, TX 77423

Adult Care

Monday, Tuesday, Thursday & Friday: 8:00 a.m. – 6:00 p.m.;
Wednesday: 7:00 a.m. – 6:00 p.m.

East Fort Bend Clinic

7707 Hwy. 6 Missouri City, TX 77459

Adult Care

Monday–Thursday: 8:00 a.m. – 5:00 p.m.

Fort Bend County Missouri City Annex

307 Texas Pkwy., Ste. 100
Missouri City, TX 77489

Adult Care

Monday, Tuesday, Thursday & Friday: 8:00 a.m. – 6:00 p.m.;
Wednesday: 7:00 a.m. – 6:00 p.m.

Pediatric Care

Tuesday: 7:00 a.m. – 7:00 p.m.;
Wednesday – Friday: 8:00 a.m. – 5:00 p.m.
2nd & 4th Saturday: 8:00 a.m. – 12:00 p.m.

Richmond Clinic

400 Austin St. Richmond, TX 77469

Adult Care

Monday–Friday: 7:00 a.m. – 6:00 p.m.;
Saturday: 8:00 a.m. – 12:00 p.m.

Pediatric Care

Monday, Tuesday, Thursday, Friday: 7:00 a.m. – 5:00 p.m.;
Wednesday: 7:30 a.m. – 5:30 p.m.;
2nd & 4th Saturday: 8:00 a.m. – 12:00 p.m.

Second Mile Clinic

1135 US-90 Missouri City, TX 77489

Adult Care

Monday, Tuesday, Thursday, & Friday 7:00 a.m. – 5:00 p.m.;

Dental

Wednesday: 7:00 a.m. – 5:00 p.m.

Stafford Clinic

10435 Greenbough Dr., Ste. 300
Stafford, TX 77477

Pediatric Care



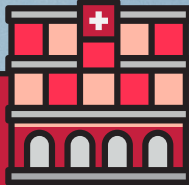
Monday–Thursday: 7:00 a.m. – 7:00 p.m.;
Friday 7:00 a.m. – 4:00 p.m.;
Saturday: 8:00 a.m. – 12:00 p.m.

Dental

Monday–Friday: 7:00 a.m. – 7:00 p.m.;
Saturday: 8:00 a.m. – 12:00 p.m.

AccessHealth, Urgent Care, or the Emergency Room

CHOOSING THE RIGHT MEDICAL CARE

 <p>1</p> <p>Primary Care</p> <p>Your FIRST STOP for every day health issues. Call to schedule a same-day appointment.</p>	 <p>2</p> <p>Urgent Care</p> <p>For injuries or illnesses that do not appear serious or life-threatening but CANNOT wait until morning.</p>	 <p>3</p> <p>Emergency Care</p> <p>Emergency departments are for medical emergencies needing IMMEDIATE medical care.</p>
Cough, cold, and flu symptoms	Suspected fractures and dislocations	Traumatic injury, broken bones and severe burns
Mild burns, minor cuts, wounds, and abscesses	Allergic reactions	Severe pain, especially in chest/stomach, uncontrolled bleeding
Check-ups and regular health screenings	Animal or insect bites	Signs of Stroke or Seizures, or sudden loss of vision
Chronic condition management	Moderate abdominal pain or discomfort	Significant difficulty breathing, severe headache
Medication questions and/or concerns	Skin infections	Possible drug overdose, toxic substance, poisoning

When to choose 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.

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.

AccessHealth

Call 24 hours a day, 7 days a week

(281) 342-4530

i 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.



Important Information for Former Military Services 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 <https://veterans.portal.texas.gov>.

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.