PATIENT REGISTRATION

Patient's Name _____ Status (S M D W)
Last First Middle

Address _____ Telephone _____
Street City State Zip

Birthdate _____ Age _____ Sex _____ Social Security # _____
Employer / School _____ Telephone _____
Address _____
Sreet or P.O. Box City State Zip Code

RESPONSIBLE PARTY

Billing Name (Other than patient) _____
Address _____
Sreet or P.O. Box City State Zip Code
Social Security # _____ Telephone _____
Next of Kin (Other than spouse) _____ Telephone _____
Address _____ Relationship _____
Sreet City State Zip

PRIMARY INSURANCE INFORMATION

Company _____ Effective Date _____
Address _____ Telephone # _____
Sreet City State Zip
D.O.B _____ Sex _____ ID# _____ Group _____
Insured Name _____ Telephone _____
Address _____ Employer / School _____
Sreet City State Zip

SECONDARY INSURANCE

Insurance Co. _____ Effective Date _____
Address _____ Telephone # _____
Sreet City State Zip
D.O.B _____ Sex _____ ID# _____ Group# _____

OFFICE CARE: We expect payment at the time of service. We will accept Cash, Personal Check or for your convenience, we have Visa & Master Charge.
INSURANCE: We recognize most HMO's and PPO's.

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits to the DOCTOR INDICATED ON THE CLAIM FORM. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY INSURANCE. A COPY OF THIS SIGNATURE IS AS VALID AS THE ORIGINAL.

Signature: _____ Date: _____

JARVIS L BULL DO

PATIENT CONSENT FOR USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION

WITH MY CONSENT, DR JARVIS L BULL MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT ME TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS (TPO). PLEASE REFER TO DR JARVIS L BULL'S NOTICE OF PRIVACY PRACTICES FOR A MORE COMPLETE DESCRIPTION OF USES AND DISCLOSURES.

I HAVE THE RIGHT TO REVIEW THE NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS CONSENT. DR JARVIS L BULL RESERVES THE RIGHT TO REVISE ITS PRIVACY PRACTICES AT ANYTIME. A REVISED NOTICE MAY BE OBTAINED FROM OUR FACILITY.

WITH MY CONSENT DR JARVIS L BULL'S OFFICE STAFF MAY CALL MY HOME OR OTHER DESIGNATED LOCATION AND LEAVE A MESSAGE ON VOICEMAIL OR IN PERSON IN REFERENCE TO ANY ITEMS THAT ASSIST THE PRACTICE IN CARRYING OUT TPO, SUCH AS APPOINTMENT REMINDERS, INSURANCE ITEMS AND ANY CALL PERTAINING TO MY CLINICAL CARE, INCLUDING LABORATORY RESULTS AMONG OTHERS.

WITH MY CONSENT DR JARVIS L BULL'S OFFICE MAY MAIL TO MY HOME OR OTHER DESIGNATED LOCATION ANY ITEMS THAT ASSIST THE PRACTICE IN CARRYING OUT TPO AS LONG AS THEY ARE MARKED PERSONAL AND CONFIDENTIAL

YOU HAVE THE RIGHT TO RESTRICT HOW WE DISCLOSE YOUR PHI.
HOWEVER, THE PRACTICE IS NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS.
BY SIGNING THIS FORM I AM CONSENTING TO DR JARVIS L BULL 'S OFFICE TO USE AND DISCLOSE MY PHI TO CARRY OUT TPO.
I MAY REVOKE MY CONSENT IN WRITING EXCEPT TO THE EXTENT THAT THE PRACTICE HAS ALREADY MADE DISCLOSURES IN RELIANCE UPON MY PRIOR CONCENT. IF I DO NOT SIGN THIS CONSENT DR JARVIS L BULL MAY DECLINE TO PROVIDE TREATMENT TO ME.
I AGREE TO AUTHORIZE INFORMATION TO PROCESS ANY MEDICAL CLAIMS AND AUTHORIZE ANY PAYMENT FOR MEDICAL / SURGICAL BENEFITS TO BE PAYED TO DR JARVIS L BULL. I AGREE TO BE RESPONSIBLE FOR PAYMENT FOR ALL NON COVERED PROCEDURES BY MY INSURANCE, IF PATIENT IS A MINOR I AGREE TO BE RESPONSIBLE FOR ALL NON COVERED PROCEDURES.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____

PRINT PATIENTS NAME

JARVIS L. BULL, D.O.
1615 PRECINCT LINE ROAD SUITE 101
HURST, TEXAS 76054
(817) 281-4910

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

JARVIS L. BULL, D.O.
1615 PRECINCT LINE ROAD SUITE 101
HURST, TEXAS 76054
(817) 281-4910

Patient Disclosure Authorization Form

Patient Name _____ Date of Birth: _____

I authorize disclosure of my protected health information only in the specific manner, for the named reason, and to the specific individual(s) described below.

Specific description of information to be used or disclosed:

_____

_____

_____
(use additional sheet if necessary)

Reason for requested use or disclosure:

☐ Patient request (personal reasons)

☐ Employment related or to substantiate a disability claim

☐ Other _____
(use additional sheet if necessary)

Office staff at this practice authorized to disclose my information (if discloser is not at this practice, ask for assistance):

_____

Person(s) or entity(ies) to whom this practice will give my information:

Name_____ Address _____

This authorization will expire on the following:

☐ Date: _____

☐ Event (relating to patient or the purpose of the disclosure): _____

_____

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the Privacy Officer at this practice, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of obtaining insurance coverage.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use or disclosure.
- I have the right to access my protected health information to be used or disclosed.
- I will receive a copy of this completed and signed authorization form.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

HEALTH HISTORY
Confidential

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking.

ALLERGIES To medications or substances

Pharmacy Name Phone

All information is strictly confidential

FAMILY HISTORY Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Strokes	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

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

If yes, please give approximate dates. _____

SERIOUS ILLNESS/INJURIES

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

OCCUPATIONAL CONCERNS

Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

Reviewed By — Date