CONROE WILLIS FAMILY MEDICINE

PATIENT PROFILE

PATIENT INFORMATION

Patient Name: _____ Gender: _____
Address: _____ Date of Birth: _____
City, Zip: _____ Social Security #: _____
Home Phone: _____ Marital Status: _____
Work Phone: _____ Cell Phone: _____
Email: _____ Referring Physician: _____

EMERGENCY CONTACTS

1. NAME: _____ PHONE: _____ RELATIONSHIP: _____
2. NAME: _____ PHONE: _____ RELATIONSHIP: _____

RESPONSIBLE PARTY *(Must complete if responsible party is other than the insured or patient)*

☐ Same as Patient ☐ Same as Insured Relation to Patient: _____
Name: _____ Employer: _____
Address: _____ Phone: _____
City, State & Zip: _____ Date of Birth: _____
Social Security #: _____

PRIMARY INSURANCE *(Must be completed in its entirety in order for us to file with your insurance)*

Name of Insured: _____ Relation to Patient: _____
Name of Insurance Company: _____ Insured ID #: _____
Insurance Phone #: _____ Policy Group #: _____
Insured Employer: _____ Insured Date of Birth: _____

IS THE PATIENT COVERED UNDER ANY OTHER INSURANCE? YES or NO
(If YES, please complete secondary insurance below.)

SECONDARY INSURANCE (if applicable)

Name of Insured: _____ Relation to Patient: _____
Name of Insurance Company: _____ Insured ID#: _____
Insurance Phone #: _____ Policy Group #: _____
Insured Employer: _____ Insured Dated of Birth: _____

I understand that this form must be completed in its entirety. I understand that if all of the above information is not completed, a claim may not be able to be filed to my insurance company; therefore, making me fully responsible for any charges incurred.

Patient/Responsible Party Signature: _____ **Date:** _____

CONROE WILLIS FAMILY MEDICINE

CONDITIONS OF SERVICE

PATIENT NAME: _____ DOB: _____ ACCT #: _____

Assignment of Benefits and Release of Patient Healthcare Information

I hereby authorize Conroe Willis Family Medicine to release patient healthcare information, compiled from the medical records pertaining to my services, in accordance with the policy of the clinic and Texas law, to facilitate reimbursement by a health benefit plan or third party payers, including but not limited to, my insurance carrier, Medicare, Medicaid, and any other payers or agencies. I also hereby authorize payment of insurance benefits under the terms of my policy directly to Conroe Willis Family Medicine for services rendered. I am financially responsible and will pay for charges not covered by my insurance plan.

X_____ _____

Patient/Guarantor Signature Date

Financial Agreement and Statement of Responsibility

For and in consideration of services rendered or to be rendered by Conroe Willis Family Medicine, I agree to pay said clinic for all services and charges. I understand that I am responsible for any health insurance deductibles, coinsurance and non-covered charges. Payment in full is due at time services are rendered or payment arrangements are to be made **before** my appointment.

X_____ _____

Patient/Guarantor Signature Date

Consent to Medical Treatment by Physician

I, or authorized representative/legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services, which may include routine diagnostic procedures and such medical treatment as the physician, his/her assistants or his/her designees consider to be necessary in his/her judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to results of treatment or examination at Conroe Willis Family Medicine.

X_____ _____

Patient/Guarantor Signature Date

Consent to Medical Treatment by Physician Assistant/Nurse Practitioner

I, or authorized representative/legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services from a Physician's Assistant and/or a Nurse Practitioner. I fully understand that Physician's Assistants and Nurse Practitioners ARE NOT PHYSICIANS. I further acknowledge that the general medical services provided to me by a Physician Assistant or Nurse Practitioner are the responsibility of the physician providing the services at Conroe Willis Family Medicine both professionally and legally, for acts of such allied health personnel rendered during the care and treatment of his/her patients.

X_____ _____

Patient/Guarantor Signature Date

Release of Patient Healthcare Information

I, or authorized representative/legal guardian acting on behalf of the patient, hereby authorize Conroe Willis Family Medicine to release patient healthcare information, in accordance with the policy of the clinic, as is necessary to healthcare providers to facilitate reimbursement by a health benefit plan or personnel of another healthcare entity for the sole purpose of providing current continuum of care including, but not limited to fax, mail or electronic submission.

X_____ _____

Patient/Guarantor Signature Date

Do you have an advanced directive (living will)? ☐ Yes ☐ No *If yes, please bring a copy into our office for our files.*

ACKNOWLEGEMENT OF REVIEW OF PRIVACY PRACTICES

I, the undersigned, have reviewed the Conroe Willis Family Medicine Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of the Privacy Practices.

Signature of Patient or Representative

Date

Printed Name of Patient or Personal Representative

Capacity of Personal Representative (Parent, Guardian, Trustee, Executor)

Address

City, State, Zip Code

CONROE WILLIS FAMILY MEDICINE

HEALTH QUESTIONNAIRE

NAME: _____ **DOB:** _____

Reason for Today's Visit (Check appropriate boxes(s) below):

☐ Establish Care ☐ Sick Visit For: _____ ☐ Recent Illness: _____

☐ Medication Refills ☐ Yearly Physical ☐ Yearly Medicare Wellness Exam

MEDICAL HISTORY

☐ Hypertension ☐ Asthma ☐ Liver Disease ☐ Stroke ☐ Cancer_____

☐ Irregular Heartbeat ☐ COPD ☐ GERD/Reflux/Ulcers ☐ Seizures ☐ Anemia

☐ Heart Attack ☐ Emphysema ☐ IBS ☐ Dementia ☐ Clotting Disorder

☐ Coronary Artery Disease ☐ Tuberculosis ☐ Crohn's ☐ Parkinson's Disease ☐ Bleeding Disorder

☐ High Cholesterol ☐ Pulmonary Hypertension ☐ Diabetes ☐ Migraines

☐ Congestive Heart Failure ☐ Thyroid Disease ☐ Mental Illness

Other: _____

SURGICAL HISTORY

Surgery/Procedure/Hospitalization	Date

SOCIAL HISTORY

Tobacco Use: ☐ Current smoker ☐ Past smoker ☐ Never

Amount: _____ Quit Date: _____

Years: _____ Years: _____

☐ Vape ☐ Chew ☐ Dip

Alcohol Use: ☐ Current drinker ☐ Past drinker ☐ Never

Caffeine Use: ☐ Yes (Amount: _____) ☐ No

Occupation: _____ Marital Status: _____

Race: ☐ American Indian or Alaska Native ☐ Asian

☐ Black or African American ☐ White

☐ Hawaiian or Other Pacific Islander ☐ Other ____

☐ Decline to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

☐ Decline to Answer

Preferred Language:

☐ English ☐ Spanish ☐ French ☐ German

☐ Russian ☐ Italian ☐ Chinese ☐ Japanese

☐ Other _____ ☐ Decline to Answer

MEDICATIONS / SUPPLEMENTS / OTCs

Name	Dosage	One a day/two a day/etc.

DRUG ALLERGIES

Allergen	Reaction

FOOD & ENVIRONMENT ALLERGIES

Allergen	Reaction

Preferred Pharmacy Name:_____ Pharmacy Phone #: _____ Pharmacy City: _____

CONROE WILLIS FAMILY MEDICINE

HEALTH QUESTIONNAIRE, CONTINUED

NAME: _____ **DOB:** _____

FAMILY HISTORY

Please indicate with an **(X)** family members who have had any of the following conditions and include their age:

	Mom	Dad	Brother	Sister	Mom's Dad	Mom's Mom	Dad's Dad	Dad's Mom	Mom's Sister	Mom's Bother	Dad's Sister	Dad's Brother
ADHD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autoimmune Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer (Specify Type)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genetic Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Immune Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Joint Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental Health Issue	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke / TIA	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other (Specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

PREVENTATIVE MEDICINE

Screening Tests:

When was your last…

	Date	Result (Circle)
Colonoscopy		Normal / Abnormal _____
Cologuard		Normal / Abnormal _____
Bone Density		Normal / Abnormal _____
Pap Smear *(Females)*		Normal / Abnormal _____
Mammogram *(Females)*		Normal / Abnormal _____
PSA *(Males)*		Normal / Abnormal _____
TB Skin Test		Normal / Abnormal _____

Immunizations:

When was your last…

	Date
Flu shot	
Tetanus Shot (Tdap or Td)	
Pneumovax (PCV23) [Pneumonia vaccine]	
Prevnar (PCV13) [Pneumonia vaccine]	
Shingrix [Shingles vaccine]	

NAME: _____ DOB: _____

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO DESIGNATED REPRESENTATIVE(S)

I, _____, give my authorization to release my protected health information including results of my laboratory test, x-ray and/or other test results to the following designated representative(s).

Patient initials

_____ My spouse (Name) _____

_____ My child (Name) _____

_____ Parent's(Name(s)) _____

_____ Other (Name) _____

_____ May be left on my answering machine at home

_____ May be left on my answering machine at work

_____ May be left on my cell phone _____

_____ MAY NOT BE GIVEN TO ANYONE OTHER THAN MYSELF

_____ _____

Patient/Representative Signature Date

_____ _____

Witness Date

As a patient, you have the right to revoke this authorization in writing at any time, except to the extent action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Conroe Willis Family Medicine must receive the revocation in writing. The revocation must include 1) the patient's name, address, and date of birth 2) the patient's desire to revoke the authorization and 3) the date of the revocation and the patient's signature. All revocations must be sent in writing to the attention of: Director of Operations at 4015 I-45 N., Suite 220 Conroe, TX 77304 or faxed to 936-494-4441 and will not be considered effective until received by this office.

Conroe Willis Family Medicine

Jason Laningham, M.D.; Joshua Dubose, M.S. PA-C; Carol Ann Leibold, MSN, RN, FNP;
Jennifer Laningham MSN, RN, FNP
Jeremy Laningham, M.D.; Simi Kosy, M.D.; John Morrow, M.D.; Evan Harbison, FNP-C; Laura Tarabocchia, FNP-C;
Gwen Dubose, M.S. PA-C

Authorization To Inspect and Release Protected Health Information

Please send records to: **4015 Interstate 45N, Suite 220 Conroe, TX 77304** **Fax: 936-494-4441**
804 West Montgomery Willis, TX 77378 **Fax: 936-890-9000**

Patient Name: _____

Address: _____

SSN: _____ **DOB:** _____

Phone Number: _____

I hereby authorize:

Name _____

Address _____

Phone _____ Fax _____

To **RELEASE** medical records to: **Conroe Willis Family Medicine**

The following health information to be disclosed is maintained in the designed record set:

☐ Last 6 months of medical records	☐ History & Physical	☐ Progress Notes
☐ Pathology Reports	☐ Radiology Reports	☐ Discharge Summaries
☐ Consult Reports	☐ Report of Procedures	☐ Laboratory Tests
☐ Other: _____		

For the purpose of continue medical treatment.

I understand that this information may include information to specific laboratory test of HIV or the diagnosis of Acquired Immune Deficiency (AIDS) or AIDs-related conditions; treatment for drug or alcohol abuse; mental or behavior health or psychiatric care, excluding psychotherapy notes.

This Authorization is given freely with the understanding that: I may revoke the authorization at any time in writing, unless the information has already been released.

Signature (Patient or Legal Guardian): _____ **Date:** _____

Name and Relationship: _____

Conroe: 4015 Interstate 45N, Suite 220 Conroe, TX 77304 **Phone:** 936-441-1122 **Fax:** 936-494-4441
Willis: 804 West Montgomery Willis, TX 77378 **Phone:** 936-890-8000 **Fax:** 936-890-9000

Jeremy Laningham, M. D.
4015 I-45 North Ste 220
Conroe, Tx 77304

CONTROLLED SUBSTANCE MANAGEMENT AGREEMENT

Name_____Date_____

The purpose of this agreement is to prevent misunderstandings about certain medications you will be taking for pain management, anxiety, or ADHD. This is to help the patient and physician comply with the law regarding controlled pharmaceuticals*

_____I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this agreement.

_____I understand that if I break this agreement, my doctor will stop prescribing these pain medications, anxiety medications, and ADHD medications.

_____In this case, my doctor will taper off the medications over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

_____I would also amenable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my doctor deems necessary.

_____I will communicate fully with my doctor about the character and intensity of my pain/anxiety, the effect of the pain/anxiety on my daily life, and how well the medicine is helping relieve my symptoms.

_____I will not use any illegal substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substance. Use of alcohol will be limited to time when I am not driving, operating machinery, and will be infrequent.

_____I will not share my medication with anyone.

_____I will not attempt to obtain any controlled medications, including opiod pain medications, controlled stimulants, or anti-anxiety medications from any other doctor.

_____I will safeguard my medications from loss or theft. ***Lost or stolen medications will not be replaced.***

_____I agree that refills of my prescriptions for controlled substance will be made only at the time of an office visit. I will call and schedule appointment for refills before I am out of my medications. No refills will be available during evenings or on weekends.

_____I authorize my doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my controlled medications. I authorize my doctor to provide a copy of this agreement of my pharmacy, or local emergency room. I agree to waive applicable privilege or right to privacy or confidentiality with respect to these authorizations.

_____I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain, anxiety, or ADHD medications.

_____I agree that I will use my medication at a rate no greater than the prescribed rate and that use of my medication at a greater rate will results in my being without medicine for a period of time. ***There are no early refills of controlled substance.***

_____I agree to follow these guidelines that have been fully explained to me.

_____I agree to use_____for all controlled substance medications.
(Name of pharmacy)

Located at_____Pharmacy Number:_____

All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

Patient signature_____Date:_____

Witnessed by:_____Date:_____