NEW PATIENT REGISTRATION INFORMATION

Patient Name: _____ Birth Date: _____

Gender: Male ☐ Female ☐ Other _____ Marital Status: _____

Ethnicity: Caucasian ☐ Hispanic ☐ African-American ☐ Asian ☐ Other ☐

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____

S.S.#_____ E-mail: _____

Emergency Contact Information

Emergency contact name: _____

Relationship to patient: _____ Phone: _____

Pharmacy Information

Name of Pharmacy: _____

Address: _____

Phone: _____ Fax: _____

Insurance Information

Primary Insurance Policy:

Insurance Name: _____ Insured's ID _____ Group#:_____

Name of Insured:_____ Insured Date of Birth: _____

Patients relation to the insured: Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Insurance Policy:

Insurance Name: _____ Insured's ID _____ Group#:_____

Name of Insured:_____ Insured Date of Birth: _____

Patients relation to the insured: Self ☐ Spouse ☐ Child ☐ Other _____

Policy Holder / Responsible Party Information (if not patient)

Name: _____ Birth Date: _____

Gender: Male ☐ Female ☐ Other ☐ Relationship to Patient: _____

Address: _____

S.S.#: _____ Phone: _____

NEW PATIENT REGISTRATION INFORMATION

If patient is a child or is incapacitated to make medical decisions on his/her own, please provide the name(s) of legal parents, custodian or legal guardian below (must provide power of attorney or legal document indicating assignee):

Parent, custodian or Legal Guardian Information

Mother's Information

Name: _____ Birth Date: _____

S.S.#: _____ Phone: _____

Father's Information

Name: _____ Birth Date: _____

S.S.#: _____ Phone: _____

Custodian/Legal Guardian's Information

Name: _____ Birth Date: _____

S.S.#: _____ Phone: _____

Authorization for Non-Legal Guardian

Provide the name(s) of individuals whom you authorize to bring your child to the doctor in case you are not able to. Ex: Step-mother, Step-Dad, Grandparents, sister, etc.
ID will be required to verify their identity.

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

_____ 6/23/2025

Signature of Parents/Legal Guardian Date

NEW PATIENT REGISTRATION INFORMATION

Please, be aware that we collect estimated insurance portions when required at each visit. Your Insurance policy is a contract between you and your insurance company. As a courtesy, we will try to verify your eligibility and file your claims with your insurance company. However, you are ultimately responsible for any unpaid balances, regardless or the original estimate of the insurance benefit. All deductibles, co-insurances and copays are due at the time of service. We will need an up-to-date copy of your insurance card on file in our office. We try to answer any question(s) you may have about your insurance policy, however, you may need to contact your insurance company directly for more accurate and complete information. If your insurance changes, it is your responsibility to provide updated Information to our office.

Assignment of Benefit

Please, read and sign to have our office file your insurance. I authorize the release of information and understand that I am responsible for all costs of medical treatment. I hereby authorize payments directly to Richard Pedroza, MD of the insurance benefits otherwise payable to me.

I also authorize, AGP Family Health Clinic to administer medical services to me that may reasonably be deemed necessary in diagnosing and treating my illness, injury or condition. By signing this document, I notify you that I have read and understood all the information herein.

Patient Signature: _____ Date: 6/23/2025

Legal Guardian Signature: _____ Date: 6/23/2025

Patient HIPAA Acknowledgement and Consent Form

_____ **(Patient initials)** Notice of Privacy Practices. I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my health information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the designated Privacy Officer if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ **(Patient Initials)** Release of information. I hereby permit practice and the physicians or other health professionals involved in my care, my child's or someone under my legal supervision, to release healthcare information for purposes of treatment, payment, or healthcare operations. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicare/Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations.

NEW PATIENT REGISTRATION INFORMATION

AGP FAMILY HEALTH CLINIC

Disclosure to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and other listed below:

Name, Relationship, Contact Number:

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

Patient Signature:_____Date: 6/23/2025

Legal Guardian Signature:_____Date: 6/23/2025

NEW PATIENT REGISTRATION INFORMATION

Authorization conditions

I may revoke this authorization in writing. If I do so, it will not affect any previous action that has already been taken based on my authorization. You may not be able to revoke this authorization if your purpose was to obtain records. I may revoke this authorization by writing a letter and sending it by certified mail, return receipt requested, to the Health Provider's Privacy Officer. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and is no longer protected by the Federal Privacy Regulations.

This authorization is valid for the release of information as stated above. Only the records of this clinic can be legally released. Any records for other physicians must be obtained from them.

Condiciones de la autorización

Patient Signature/Firma del Paciente: _____ Date/Fecha:__6/23/2025____

Legal Guardian/Guardián Legal: _____ Date/Fecha:__6/23/2025____

AGP FAMILY HEALTH CLINIC

Authorization to Obtain/Release Medical Information
Fax: (832)698-2976

You must complete this form thoroughly.

Patient's Name:_____ Date of Birth: _____ / _____ / _____

Home Address: _____

I hereby authorize Magnificat Primary Care & Wellness Center to obtain or share my medical information.

Unless otherwise stated, records will be shared with them. Please submit records within 14 business days.

Name of previous Physician or Medical Facility: _____

Address: _____

Phone: _____ Fax: _____

The information that will be disclosed: **All Medical Records .**

Current treating physicians with whom we may send/receive health information with:

Name: Richard Andres Pedroza M.D. **Address: 888 Graham Dr.,Tomball, TX 77375**

Specialty: Family Medicine Physician **Phone: (832) 684-3939**

Conditions of Authorization

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain records. I may revoke this authorization by writing a letter and mailing it certified, return receipt requested, to the Privacy Officer at the health provider listed above. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Privacy Regulations.

This authorization is valid for the release of information as indicated above. Only records from this facility can be legally released. Any records for other physicians can be obtained from them.

Signature: _____ Date: _____ / _____ / _____

Parent/Guardian Signature: _____ Date: _____ / _____ / _____

NEW PATIENT REGISTRATION INFORMATION

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

When you receive treatment at our clinic, we receive, create and maintain information about your health, treatment, and payment for services. We will not use or disclose your information without your written authorization (permission) except as described in this notice.

How We May Use and Disclose Your Health Information

We may use and disclose your health information without your authorization for treatment, payment, and health care operation purposes. Examples include but are not limited to:
Using or sharing your health information with other health care providers involved in your treatment or with a pharmacy that is filling your prescription.

Using or sharing your health information with your health plan to obtain payment for services or using your health information to determine your eligibility for government benefits in a health plan.
Using or sharing your health information to run our business, to evaluate provider performance, to educate health professionals, or for general administrative activities.

We may share your health information with our business associates who need the information to perform services on our behalf and agree to protect the privacy and security of your health information according to agency standards.

We may use or share your health information without your authorization as authorized by law for our patient directory, to family or friends involved in your care, or to a disaster relief agency for purposes of notifying your family or friends of your location and status in an emergency situation.

We may use and disclose your health information without your authorization to contact you for the following activities, as permitted by law and agency policy: providing appointment reminders; describing or recommending treatment alternatives; providing information about health-related benefits and services that may be of interest to you; or fundraising.

We may also use and disclose your health information without your authorization for the following Purposes:
For public health activities such as reporting diseases, injuries, births or deaths to a public health authority authorized to receive this information, or to report medical device issues to the FDA;

To comply with workers compensation laws and similar programs;

To alert appropriate authorities about victims of abuse, neglect, or domestic violence; if the agency reasonably believes you are a victim of abuse, neglect, or domestic violence we will make every effort to obtain your permission, however, in some cases we may be required or authorized to alert the authorities;

For health oversight activities such as audits, investigations, and inspections of our facilities;

For research approved by an Institutional Review Board or privacy board; for preparing for research such as writing a research proposal; or for research on decedents information;

To create or share de-identified or partially de-identified health information (limited data sets);

For judicial and administrative proceedings such as responding to a subpoena or other lawful order;

For law enforcement purposes such as identifying or locating a suspect or missing person;

To coroners, medical examiners, or funeral directors as needed for their jobs;

To organizations that handle organ, eye or tissue donation, procurement, or transplantation;

To avert a serious threat to health or public safety;

For specialized government functions such as military and veteran activities, national security and intelligence activities, and for other law enforcement custodial situations;

For incidental disclosures such as when information is overheard in a waiting room despite reasonable steps to keep information confidential; and

As otherwise required or permitted by local, state, or federal law.

Additional privacy protections under state or federal law apply to substance abuse information, mental health information, certain disease-related information, or genetic information. We will not use or share these types of information unless expressly authorized by law. We will not use or disclose genetic information for underwriting purposes.

We will always obtain your authorization to use or share your information for marketing purposes, to use or share your psychotherapy notes, if there is payment from a third party, or for any other disclosure not described in this notice or required by law. You have the right to cancel your authorization, except to the extent that we have taken action based on your authorization. You may

cancel your authorization by providing a written request to our privacy officer.

Your Privacy Rights

Although your health record is the property of AGP Family Health Clinic, you have the right to: Obtain a copy of your health information, including lab reports, upon verbal or written request as required and subject to some exceptions. We may charge you a reasonable, cost-based fee for providing records as permitted by law.

Receive confidential communications of your health information, such as requesting that we contact you at a certain address or phone number. You may be required to make the request in writing with a statement or explanation for the request.

Request amendment of your health information in our records. All requests to amend health information must be made in writing and include a reason for the request.

Request an accounting (a list) of certain disclosures of your health information that we make without your authorization. You have the right to receive one accounting free of charge in any twelve-month period.

Request that we restrict how we use and disclose your health information for treatment, payment, and health care operations, or to your family and friends. We are not required to agree to your request, except when you request that we not disclose information to your health plan about services for which you paid with your own money in full.

Obtain a paper copy of this notice upon request.

Our Duties

We are required to provide you with notice of our legal duties and our privacy practices with respect to your health information. We must maintain the privacy of information that identifies you and notify you in the event your health information is used or disclosed in a manner that compromises the privacy of your health information.

We are required to abide by the terms of this notice. We reserve the right to change the terms of this notice and to make the revised notice effective for all health information that we maintain. We will post revised notices on our public website at www.dshs.texas.gov and in waiting room areas. You may request a copy of the revised notice at the time of your next visit.
We will not retaliate against you for filing a complaint.

Revised on 06/14/2022.

NEW PATIENT REGISTRATION INFORMATION

Medical History Questionnaire

Briefly describe your current health problems.

_____

_____

_____

Hospitalizations in the past year (including where, when, and why):

_____

_____

_____

_____

Please indicate the names of the providers who currently serve you:

When was the last vision exam/name of specialist?

_____

When was your last dental exam/name of specialist?

_____

When was your last foot exam/name of specialist?

_____

When was your last skin exam/name of specialist?

_____

REGISTRATION FORM FOR NEW PATIENTS

Basic directives

Hopefully not anytime soon, but if an illness suddenly happens or gets worse, would the patient:

- ☐ Prefer to not go to the hospital, no matter what treat conservatively with only medications, if it doesn't respond then pass away at home with comfort medications.
- ☐ Go to hospital to diagnose and stabilize, but use only medications, comfort care only if worsening
- ☐ Go to hospital, treatment includes ventilator/artificial respiration for up to 2 weeks if necessary, but without aggressive cardiopulmonary resuscitation
- ☐ Go to hospital with treatment to include a ventilator for an extended period if necessary, but without aggressive CPR
- ☐ Go to the hospital with treatment that includes a ventilator and aggressive CPR

The preference can always be changed, but it is helpful to have a basic understanding before an emergency arises.

**Aggressive cardiopulmonary resuscitation includes chest compressions, broken ribs, electroshocks to the heart, medications to artificially maintain blood pressure, with a 15% short-term survival rate after age 80.*

Medicines

Do you have allergies to a medication?

- ☐ No
- ☐ Yes to what?

_____

Please list the medications you are taking now. Include over-the-counter medications and vitamins or supplements:

Name of drug	Dosage (strength and number of pills per day)	Reason for taking?	Concerns?

REGISTRATION FORM FOR NEW PATIENTS

Past Medical History

Does the patient now or has ever had:

- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypothyroidism
- ☐ skin breakdowns
- ☐ Cancer (type) _____
- ☐ Seizures
- ☐ Angina
- ☐ Heart problems
- ☐ heart murmur
- ☐ Pneumonia
- ☐ Pulmonary embolism
- ☐ Asthma
- ☐ Emphysema
- ☐ Strokei
- ☐ Cateracts
- ☐ kidney disease
- ☐ Kidney stones
- ☐ Crohn's disease
- ☐ Colitis
- ☐ Anemia
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Stomach or peptic ulcer
- ☐ Tuberculosis
- ☐ HIV/AIDS

Other medical conditions (please list):

_____

_____

_____

_____

REGISTRATION FORM FOR NEW PATIENTS

In the past month, has the patient had any of the following problems?

General
- ☐ Weight gain, how much? ____
- ☐ Weight loss, how much? _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Night sweats

Muscle/Joints/Bones
- ☐ Numbness
- ☐ Joint pain
- ☐ Muscular weakness
- ☐ Joint inflammation, where? _____

Ears
- ☐ Ringing in the ears
- ☐ Loss of hearing

Eyes
- ☐ Pain
- ☐ Redness
- ☐ Double vision
- ☐ blurry vision
- ☐ Dryness

Heart and Lungs
- ☐ Chest pain
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Swollen legs or feet

Nervous system
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting or loss of consciousness
- ☐ Numbness or tingling
- ☐ Memory loss

Stomach and intestines
- ☐ Nausea
- ☐ Heartburn
- ☐ Stomach pain
- ☐ Vomiting
- ☐ yellow jaundice
- ☐ Increased constipation
- ☐ Persistent diarrhea
- ☐ Blood in the stool
- ☐ black stool

Skin
- ☐ Redness
- ☐ Rash
- ☐ Hair loss
- ☐ Color changes in hands or feet

Blood
- ☐ Anemia
- ☐ Blood clots

Renal/urinary/bladder
- ☐ Frequent or painful urination

Psychiatricians
- ☐ Depression
- ☐ Excessive worries
- ☐ Difficulty to sleep
- ☐ Difficulty staying asleep
- ☐ Anxiety
- ☐ Little appetite
- ☐ Food cravings
- ☐ Frequent crying
- ☐ Humor changes
- ☐ suicidal thoughts/attempts
- ☐ stress
- ☐ Irritability
- ☐ Bad concentration
- ☐ Racing thoughts
- ☐ Hallucinations
- ☐ quick speech
- ☐ guilty thoughts

Other medical problems (please indicate):