

# Blanco Regional Clinic, PA

## PATIENT INFORMATION

NAME: \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

HM# \_\_\_\_\_ CELL# \_\_\_\_\_ EMAIL \_\_\_\_\_

PREFERRED PHARMACY \_\_\_\_\_ PH# \_\_\_\_\_

MARRIED SINGLE DIVORCED WIDOWED

PLEASE SELECT ONE OF THE FOLLOWING: WHITE BLACK HISPANIC ASAIN AMERICAN INDIAN OTHER

Employer: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### INSURANCE: POLICY HOLDER INFORMATION:

NAME \_\_\_\_\_ DOB \_\_\_\_\_

### ASSIGNMENT OF BENEFITS:

Our office will file insurance for all reimbursable services to your primary insurance carriers. Please remember that you are responsible for all deductibles, co-pays, and non-covered services. These fees are due at the time of your office visit. I assign benefits to Blanco Regional Clinic, PA for all health services provided to me. I understand that BRC has the right to refuse or accept assignments of such benefits.

\_\_\_\_\_  
Signature of patient or responsible party

\_\_\_\_\_  
Date

### HIPAA INFORMATION

I acknowledge that BRC, PA has provided me with a written copy of the Notice of Privacy Practices, and I have afforded the opportunity to read and ask questions about the Notice of Privacy Practices.

**May we release health information about you to family members or other individuals? Yes or No**

**If you answered yes, please list the names of each individual.**

\_\_\_\_\_  
Name relationship phone

\_\_\_\_\_  
Name relationship phone

\_\_\_\_\_  
Name relationship phone

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE NOTE THAT IT IS THE RESPONSIBILITY OF THE PATIENT OR LEGAL GUARDIAN TO NOTIFY OUR OFFICE IF ANY OF THE ABOVE CONTACT INFORMATION CHANGES.**

**PAST MEDICAL HISTORY**

PLEASE CIRCLE WHAT APPLYS

ACNE	GLAUCOMA	SEIZURES
ADD/ADHD	GOUT	SINUS INFECTIONS CHRONIC
ANEMIA	HEART CONDITION	SLEEP DISORDER
ANXIETY	Specify_____	STD TYPE_____
ASTHMA	HEPATITIS TYPE_____	STOMACH ULCERS
BIPOLAR DISORDER	HIGH BLOOD PRESSURE	STROKE
BLOOD CLOT	KIDNEY DISEASE	THYROID DISEASE
CANCER TYPE_____	KIDNEY INFECTIONS	TUBERCULOSIS
CHRONIC BRONCHITIS	KIDNEY STONES	ULCERATIVE COLITIS
COLON POLYPS	LUPUS	WARTS
CHRON'S DISEASE OR IBS	MIGRAINES	
DEMENTIA	OSTEOARTHRITIS	
DEPRESSION	OSTEOPENIA	
DIABETES	OSTEOPOROSIS	
DIVERTICULITIS	PROSTATE PROBLEMS	
EATING DISORDER	REFLUX (HEARTBURN)	
ECZEMA	RHEUMATOID ARTHRITIS	
EMPHYSEMA	ROSACEA	
FREQUENT UTI'S	SCHIZOPHRENIA	
GALLSTONES	SEASONAL ALLERGIES	

**SURGICAL HISTORY**

<u>SURGERY</u>	<u>YEAR</u>	<u>COMPLICATIONS</u>
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-

**PLEASE LIST DATE OF LAST EXAM:**

COLONOSCOPY\_\_\_\_\_ BONE DENSITY\_\_\_\_\_ PNEUMONIA VACCINE\_\_\_\_\_ FLU VACCINE\_\_\_\_\_

MAMMOGRAM\_\_\_\_\_ PAP\_\_\_\_\_ EYE EXAM\_\_\_\_\_ DENTAL EXAM\_\_\_\_\_ PROSTATE\_\_\_\_\_

COVID VACCINE\_\_\_\_\_ Tdap\_\_\_\_\_

**FAMILY HISTORY**

DISEASE	SPECIFICITY	FAMILY MEMBER	CAUSE OF DEATH YES OR NO?
CANCER			
DIABETES			
HEART DISEASE (SPECIFY)			
GENETIC			
PSYCH			

**SOCIAL HISTORY**

Do you have a living will, DNR or medical power of attorney? Yes or no

Do you exercise? Y or N How often? \_\_\_\_\_

Are you sexually active? Y or N Birth Control used: none condoms pill other \_\_\_\_\_

Do you smoke? Y or N If so how many packs a day \_\_\_\_\_ how long \_\_\_\_\_ if you quit what year \_\_\_\_\_

Do you consume alcohol? Y or N How many drinks day or week? \_\_\_\_\_

Do you consume Caffeine? Y or N How many a day? \_\_\_\_\_

Do you use illegal substances? Y or N if so what type \_\_\_\_\_

**CURRENT MEDICATIONS**

DRUG NAME	STRENGTH	HOW OFTEN DO YOU TAKE IT

**MEDICATION ALLERGIES**

DRUG NAME	REACTION

**Blanco Regional Clinic, P.A.  
825 Fourth Street  
Blanco, TX 78606  
830-833-5581**

Date \_\_\_\_\_

**Mid-Level Provider Consent Form**

**This practice utilizes Physician Assistants (PA's) and Nurse Practitioners (FNPs) to provide health care. PAs and FNPs are educated, licensed and nationally certified providers that work in conjunction with a supervising physician. There is on-going communication between the physician and the Mid-level providers regarding patient care. If at anytime a patient requests an appointment with the physician, this request will be granted at the first availability.**

**I voluntarily consent to evaluation and treatment by the physician, physician assistant or family nurse practitioner on staff at Blanco Regional Clinic, P.A. I understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of treatments or examination by the staff.**

**I have read the above regarding Mid-Level providers. I hereby give my consent to treatment.**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

## MEDICAL APPOINTMENT CANCELLATION /NO SHOW POLICY

Thank you for trusting your medical care to **Blanco Regional Clinic, P.A.** When you schedule an appointment with us, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show policy below:

Effective August 1, 2024, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours' notice** will be considered a **No Show** and will incur a **\$50.00** no show fee.

Any New Patient who fails to show for their initial visit will not be rescheduled.

As a courtesy, **when time allows**, we make reminder calls for annual appointments. If you do not receive a reminder call or message, the above policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our office, we may be able to waive the No Show Fee.

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Patient

Date