Patient Registration and Medical History

Thank you for choosing Zana's Place for your healthcare needs. Please fill out this form so that we can understand and treat your health issues to the best of our ability. Please **print** in blue or black ink.

General Information			
First Name:	MI:	Last Name:	
Date of Birth: / /	Sex: ☐ Male ☐ Female	Social Security Number: - -	
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed			
Highest Level of Education: ☐ Grade School ☐ High School ☐ College ☐ Professional ☐ Technical/Business			
What kind of hobbies do you enjoy?:			
Birthplace (City, State, or Country):			
Where else have you lived?			
Contact Information			
Mobile Phone:	Email Address:		
Home Phone:	Work Phone:	Work Ext.:	
Preferred Method of Communication: ☐ Mobile Phone	☐ Home Phone	☐ Work Phone	
Address:	Apt. Suite or Floor:		
Zip: City:	State:		
Employer Address (City, State, Zip):			
Demographics			
Ethnicity:	Race:	Preferred Language:	
Weight:	Height (Feet/Inches)		
Next of Kin			
Emergency Contact Name:	Phone:		
Emergency Contact Address:			
Zip: City:	State:		
Emergency Contact Relationship to You:			
Mother's Maiden Name:			
Health Care			
Preferred Pharmacy:	Pharmacy Phone:		
Primary Care Physician:			
Cardiologist:	OB/GYN:		
Referred Here By:			
Please give a brief history of your current problems:			
How did you hear about us?			

Treatment Authorization and Insurance Waiver

I authorize Zana's Place to treat me. I have been informed that this facility does not accept any form of health insurance. This includes Medicare, Medicaid, Worker's Comp, or any type of private insurance. I understand that I am financially responsible for services rendered to be at the time of service. This waiver serves as my decision to waive usage of my medical insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

Signed: _____ Date: _____ / _____ / _____

Witness:_____ Date: _____ / _____ / _____

Medical Information Release Form
(HIPAA Release Form)

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

Release of Information

☐ I authorize the release of information including the diagnosis, records, examinations rendered to me and claims information. This information may be released to:

☐ Spouse _____ Contact Number: _____

☐ Child(ren) _____ Contact Number: _____

_____ Contact Number: _____

☐Other _____ Contact Number: _____

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please Call: ☐ My home ☐ My work ☐ My cell phone number:_____

If unable to reach me

Please check one.

☐ You may leave a detailed message

☐ Please leave a message asking me to return your call

☐ Other: _____

Signed: _____ Date: _____ / _____ / _____

Witness:_____ Date: _____ / _____ / _____

Patient Name: _____ Date: _____

Occupational Information

What kind of work do you do?
How long have you done this kind of work?
Are you satisfied with your work?
What other kinds of work have you done?
Are you aware of any hazardous exposures associated with your present or past jobs? (Please list.)
Have you ever changed jobs for health reasons?
Were you in the military? ☐ Yes ☐ No Were you medically retired from the military? ☐ Yes ☐ No Were you refused entry into active duty for health reasons? ☐ Yes ☐ No
Have you received Workmen's Compensation or other disability compensation? ☐ Yes ☐ No

Family History

Please check if your blood relatives had any of the following:

☐ Disease	Relationship to You
☐ Blood disorders	
☐ Cancer (explain)	
☐ Diabetes	
☐ Breast disease (explain)	
☐ Heart disease	
☐ High blood pressure	
☐ Kidney disease	
☐ Mental illness	
☐ Prostate cancer	
☐ Thyroid disease	
☐ Other (please explain) _____	

Hospitalizations

Please list any hospitalizations due to illness, injury, or surgery.

Date	Reason for Hospitalization

Social History

Do you follow a particular diet? ☐ Yes ☐ No (If yes, please explain):
Do you drink coffee or hot tea? ☐ Yes ☐ No If yes, how many cups per day:
Do you exercise regularly? ☐ Yes ☐ No If yes, how often: What type of exercise: For how long:
Do you or have you ever smoked? ☐ Yes ☐ No If yes, how many packs per day: How long have you smoked?
Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how many per day: Were you a heavy drinker in the past? ☐ Yes ☐ No
Do you use recreational drugs? ☐ Yes ☐ No If yes, how often:

Pregnancies

Year of Birth	Sex of Baby	Any Complications:

Women's Health

Date of last period: Length:
Since you first began having periods, have you ever had what you would consider to be abnormal cycles? ☐ Yes ☐ No If yes, please explain (such as age when this occurred, symptoms, etc.)
Are you married? ☐ Yes ☐ No If yes, for how many years?
Are you sexually active? ☐ Yes ☐ No
Date of last pap smear: Mammogram: Have you ever had an abnormal pap or mammogram result? ☐ Yes ☐ No If yes, explain:
Age at onset of menstruation:
Do you use any contraceptives? ☐ Yes ☐ No If yes, what kind?
If past menopause, at what age did menstruation stop:
Have you had a hysterectomy? ☐ Yes ☐ No If yes, why? Have you had ovaries removed? ☐ Yes ☐ No Have you had a tubal ligation? ☐ Yes ☐ No

Patient Name: _____ Date: _____

Medical Conditions

Check all conditions you currently have or have had in the past year.

- ☐ Anemia
- ☐ Asthma
- ☐ Breast Cancer
- ☐ Breast Lumps
- ☐ Cancer:_____
- ☐ Diabetes
- ☐ Heart Disease: _____
- ☐ High cholesterol
- ☐ Hypertension
- ☐ Kidney Disease: _____
- ☐ Liver Disease: _____
- ☐ Migraine Headaches
- ☐ Psychiatric disease: _____
- ☐ Thyroid Disease: _____
- ☐ Other:_____

Infections

Check all conditions that you have had in the past and the date of infection, if known.

☐ Mononucleosis _____ ☐ Chicken Pox _____ ☐ STD_____

Prescription Medications

List all medications you currently take.

Prescription Medication Name	Strength/Dosage	Date Started	Directions

Vitamins and Supplements

Please identify and list the health products you are currently using.

Product Name	Directions

Drug Allergies

List medications you cannot take and the problem it causes.

Medication	Reaction

Seasonal and Environmental Allergies

If you have any other allergies, please explain:

Patient Name: _____ **Today's Date:** _____

Symptoms

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

General

- ☐ Bothered by Hot or Cold Weather
- ☐ Bruise Easily (or bleeding gums)
- ☐ Chills
- ☐ Coughing Up Blood
- ☐ Dizziness
- ☐ Fainting
- ☐ Feel "Run Down"/Tire Easily
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Lymph Node Enlargement
- ☐ Nervousness
- ☐ Numbness
- ☐ Shortness of Breath
  ☐ at rest ☐ at night ☐ with exertion
- ☐ Sweating
- ☐ Weight Gain/Loss (without dieting)
- ☐ Wheezing

Muscle/Joint/Bone

- ☐ Back Brace
  (or other orthopedic appliances)
- ☐ Joint Pain, Swelling or Stiffness

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

Cardiovascular

- ☐ Chest Pain or Discomfort
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Palpitations
- ☐ Poor Circulation
- ☐ Rapid Heart Beat
- ☐ Swelling of Ankles
- ☐ Vericose Veins

Gastrointestinal

- ☐ Abdominal Pain/Colic
- ☐ Appetite Poor/Loss
- ☐ Black/Tarry Bowel Movements
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hiatal Hernia
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

Genito-Urinary

- ☐ Blood in Urine
- ☐ Difficulty in Starting Stream
- ☐ Dribbling at End of Stream
- ☐ Frequent Urination
- ☐ Lack of Bladder Control
- ☐ Painful/Burning Urination

Skin

- ☐ Bruise Easily
- ☐ Dry Skin/Hair
- ☐ Eczema (or other rashes)
- ☐ Hives
- ☐ Itching
- ☐ Moles (new or changes in moles)
- ☐ Numbness of Skin
- ☐ Rash
- ☐ Scars
- ☐ Skin Cancers
- ☐ Sore That Won't Heal

Eyes/Ears/Nose/Throat

- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache
- ☐ Ear Discharge
- ☐ Ear Infection
- ☐ Frequent Sore Throat
- ☐ Hay Fever
- ☐ Hoarseness (persistent)
- ☐ Loss of Hearing
- ☐ Lumps or Swelling in Neck
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing or Buzzing in Ears
- ☐ Serious Loss of Vision in Either Eye
- ☐ Sinus Problems
- ☐ Vision (Flashes)
- ☐ Vision (Halos)

Psychiatric

- ☐ Changes in Appetite
- ☐ Depression
- ☐ Difficulty Concentrating
- ☐ Difficulty Sleeping
- ☐ Excessive Fatigue
- ☐ Feelings of Guilt/Worthlessness
- ☐ Loss of Interest in Hobbies
- ☐ Thoughts of Suicide

Neurological

- ☐ Anxiety/Irritability
- ☐ Confusion
- ☐ Frequent Headaches
- ☐ Memory Loss
- ☐ Paralysis (of any part)
- ☐ Weakness of Muscles

MEN Only

- ☐ Breast Lump
- ☐ Decreased Sex Drive
- ☐ Enlarged Prostate
- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Pain or Swelling of Testicles
- ☐ Penis Discharge
- ☐ Prostate Cancer
- ☐ Prostate Problems
- ☐ Sore on Penis
- ☐ Other (Please Explain):

WOMEN Only

- ☐ Abnormal Pap Smear
- ☐ Bleeding Between Periods
- ☐ Breast Lump
- ☐ Breast Pain/Tenderness
- ☐ Decreased Sex Drive
- ☐ Difficulty Climaxing
- ☐ Extreme Menstrual Pain
- ☐ Fibrocystic Breast
- ☐ Fluid Retention
- ☐ Hair Loss
- ☐ Hot Flashes
- ☐ Irregular Periods
- ☐ Mood Swings
- ☐ Night Sweats
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ PMS (☐ mild ☐ moderate ☐ severe)
- ☐ Severe Menstrual Cramps
- ☐ Vaginal Discharge
- ☐ Vaginal Dryness
- ☐ Unusually Heavy Periods
- ☐ Other (please explain):

Are you pregnant? ☐ Yes ☐ No

Medical Records Release Form

Patient Name (printed)	Social Security Number	Date of Birth

From: (name) _____

(address) _____

_____

Phone Number: _____ Fax Number: _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or narrative of my protected health information, to the person or entity listed below.

Release my protected health information to the following person/entity.

Zana's Place
967 Pruitt Place
Tyler, TX 75703
Phone: 903-266-1599
Fax: 903-266-1589
Zana Elliott, FNP

Limitations on the information you may release subject to this ***Release Form*** are as follows:

☐ My X-Rays/Studies
☐ A copy of my X-Ray reports from _____ to _____
☐ A copy of ALL of my medical records
☐ A copy of my medical records from _____ to _____
☐ Labs only

The reason or purpose for this release of information are as follows:

_____

_____

_____

Patient Signature (or parent, guardian, or legal representative)	Date

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings by the Texas State Board of Medical Examiners.

Office Policies

It is our intention to provide all of our patients with the best care possible. For this reason, we ask you to take a few moments to review policies that affect the way our services are provided.

Cancellations and No-Shows Policy
It is extremely important that scheduled appointments be kept. A 24-hour notice must be given for all cancellations or an administrative fee will be charged to your account. Multiple cancellations can require prepayment for visits or dismissal of care.
If a patient no-shows multiple appointments, they will be subject to a higher administrative fee up to and including the cost of the visit, and they may be required to prepay for any future visits. Patients who do not show up for an excessive amount of appointments may be discharged from the practice.

Arrive Early
In order to complete the necessary paperwork for your appointment, please arrive 10 minutes before the scheduled time. Patients who arrive on time for their appointments will be seen ahead of those who arrive late. If you arrive more than 10 minutes late for your appointment, the appointment may be shortened to a nurse visit only or rescheduled for another time.

Cell Phone Usage
Please refrain from talking on the phone in the waiting room or examination rooms as a courtesy to our patients and staff.

Prescription Refills
Please have your pharmacy fax your refill request to (903) 266-1589. Provided you are up to date on necessary exams and laboratory work, your refill may be processed within 72 HOURS, so please plan accordingly. Your refill request may be denied should you fail to comply with our policy. Refills of prescription medications that fall under the general category of CONTROLLED SUBSTANCES such as narcotics, certain mood-altering agents, and appetite suppressants will require regular visits as defined by the provider. If you believe that a refill request was denied in error, please call us at (903) 266-1599 and leave a message for the nurse so that the matter may be investigated.

Communications
Please allow 2 business days for non-urgent messages and requests to be addressed by the staff. If you have a medical emergency, please call 911 or go to your local emergency room.

Payments
Payment in full is due at the time services are rendered. We accept credit/debit cards. We also accept money orders, cashier checks, personal checks & cash. A $25 service fee will be charged for returned checks due to insufficient funds. We may also elect to discharge you from our practice should you fail to comply with our policy.

Signed: _____ Date: _____ / _____ / _____

Witness:_____ Date: _____ / _____ / _____