- **Phone Number: 432-231-0100**
- **Address: 5000 Briarwood Ave., Ste. 203, Midland, Texas 79707**

Today's Date:_____
Last Name:_____
First Name:_____
Middle Name:_____
Age:____
Sex:_____
Street address:_____
Social Security No:_____
Date of Birth:_____
Home Phone No:_____
City:_____
State:_____
Zip Code:_____
Cell Phone No:_____
Occupation:_____
Employer:_____
Employer Phone No:_____

REQUIRED BY GOVERNMENT MANDATE (MAY REFUSE)
Language:_____
Race:_____
Ethnicity:_____
Marital Status:_____

REFERRED BY:
Walk In ☐
TV Ad ☐
Online ☐
Phonebook ☐
Family/Friend Other:_____

EMAIL ADDRESS:_____

INSURANCE INFORMATION
(Please give your insurance card to the receptionist)
Person responsible for bill:_____
Birth date:_____

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Address (if different):_____
Home Phone No:_____

Is this person a patient here?
Yes ☐
No ☐

Occupation:_____
Employer:_____
Employer Address:_____
Employer Phone No:_____

Is this patient covered by insurance?
Yes ☐
No ☐

Please Indicate Primary Insurance:_____

Subscriber's Name:_____
Subscriber's S.S. No:_____
Birth date:_____
Group No:_____
Policy No:_____
Co-Payment :_____

Patient's Relationship to Subscriber:
Self ◯
Spouse ◯
Child ◯
Other

Name of Secondary Insurance (If applicable):
Subscriber's Name:_____
Group No:_____
Policy No:_____

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Patient's Relationship to Subscriber:
Self ◯
Spouse ◯
Child ◯
Other

IN CASE OF EMERGENCY

Name of Local Friend or Relative:_____
Relationship to Patient:_____
Home Phone No:_____
Work Phone No:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Briarwood Clinic or Insurance Company to release any information required to process my claims.

_____ _____
Patient/Guardian Signature *Date*

Patient Name: _____
Date of Birth: _____

INTERNAL MEDICAL HEALTH HISTORY QUESTIONNAIRE

Your answers will help your health care provider better understand your medical concerns and conditions. Please answer to the best of your knowledge.
Questions contained in this questionnaire are optional and will be kept strictly confidential.

Main reason for today's visit: _____

Other concerns: _____

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ALLERGIES

LIST ANYTHING THAT YOU ARE ALLERGIC TO (MEDICATIONS, FOOD, BEE STINGS, ECT.) AND REACTIONS.

ALLERGY: REACTION:

1._____ _____

2. _____ _____

3. _____ _____

MEDICATIONS

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING, INCLUDING OVER THE COUNTER, VITAMINS AND INHALERS.

DRUG NAME STRENGTH FREQUENCY TAKEN

1._____ _____ _____
2._____ _____ _____
3._____ _____ _____
4._____ _____ _____
5._____ _____ _____

PREFERRED PHARMACY: _____
PHONE NUMBER: _____
PATIENT MUST BRING ALL CURRENT MEDICATIONS TO EVERY VISIT!
IF YOU DO NOT HAVE YOUR MEDICATIONS, YOU MUST PROVIDE A LIST OF ALL CURRENT MEDICATIONS, ALONG WITH DOSE AND FREQUENCY. IF YOU CANNOT PROVIDE EITHER, WE WILL REQUIRE YOU TO CONTACT YOUR PHARMACY AND GET THE INFORMATION PRIOR TO BEING SEEN! A LIST OF PHARMACIES ALONG WITH THEIR CONTACT INFORMATION IS AVAILABLE AT THE FRONT DESK IF NEEDED.

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Date of Birth: _____

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PAST MEDICAL HISTORY

CONDITION/DISEASE	YEAR	OTHER CONDITION/DISEASE	YEAR
Hypertension	____	_____	_____
Heart Disease	____	_____	_____
High Cholesterol	____	_____	_____
Diabetes	____	_____	_____
Gastrointestinal	____	_____	_____
Respiratory, COPD, Asthma	_____	_____	_____
Depression or Anxiety	____	_____	_____

PAST MEDICAL PROCEDURES/ HOSPITALIZATIONS/ SERIOUS INJURIES

OPERATION/HOSPITALIZATION	MO/YR	MO/YR

FAMILY HISTORY

RELATIVE	HEALTH PROBLEMS/IF DECEASED, CAUSE OF DEATH	AGE

Marital Status:
Single Married ◯
Divorced ◯
Separated ◯
Widowed ◯
Domestic Partner ◯

Highest Level of Education:
GED Diploma ☐
2yr. College ☐
4yr. College ☐
Post Graduate ☐
None ☐

Caffeine Intake: Occasional Moderate Heavy # of cups/cans per day?_____

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Alcohol Intake: None Occasional Moderate Heavy # of drinks per week:_____
Tobacco
Y ☐
N ☐
How many years?_____
Recreational / Addict drugs: If Yes, list below
_____
Cigarettes/Packs per day:_____
Chew/Cans per day?:_____

DISEASE PREVENTION AND HEALTH MAINTENANCE

MO/YR

FLU VACCINE HEPATITIS B MO/YR:_____
MAMMOGRAM MO/YR:_____
PNEUMONIA VACCINE MO/YR:_____
SHINGLES VACCINE MO/YR:_____
HEART STRESS TEST MO/YR:_____
TETANUE MO/YR:_____

GARDASIL VACCINE MO/YR:_____

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PERSONAL REPRESENTATION AUTHORIZATION FOR MEDICAL RELEASE FORM

I authorize this facility and staff to speak to the following family members or my personal representative on my behalf.

All medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays and reports, history, laboratory findings, admissions and discharge reports, treatment record, diagnosis and prognosis and records, nurse and doctor notes and any other non-medical information in my life.

Only the following types of information:

_____
_____
_____

The above medical information shall only be released to the following person:

FAMILY MEMBER/PERSONAL REPRESENTATIVE	RELATIONSHIP
_____	_____
_____	_____
_____	_____

I understand that I may terminate this Medical Authorization form. I must notify Briarwood Clinic in writing regarding termination and effective date.

This authorization form shall remain valid (check one)
Until revoked in writing.
Until Date/YR _____

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I know that I am entitled to receive a copy of this agreement.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

BRIARWOOD CLINIC FINANCIAL POLICY
BRIARWOOD CLINIC WELCOMES YOU TO OUR FACILITY!

PRIVATE PAY PATIENTS

ALL SERVICES ARE REQUIRED TO BE PAID AT THE TIME OF SERVICE.
YOU WILL RECEIVE A 25% DISCOUNT ON ALL SERVICES AS A COURTESY FOR YOUR PROMPT PAYMENT.

INSURANCE AND MEDICAID PATIENTS

ALL INSURANCE CARDS MUST BE PRESENTED AT THE TIME OF REGISTRATION. IF FOR ANY REASON YOU DO NOT PROVIDE THE CORRECT INFORMATION, YOU WILL BE RESPONSIBLE FOR ALL CHARGES.

ALL CO-PAYS, DEDUCTIBLES AND COINSURANCE ARE REQUIRED TO BE PAID AT THE TIME OF SERVICE.

IF THE PROVIDER THAT YOU SEE IS OUT OF THE NETWORK WITH YOUR INSURANCE CARRIER, YOU WILL BE ASKED TO PAY FOR THE SERVICES AND A CLAIM WILL BE FILED ON YOUR BEHALF AS A COURTESY. iT IS YOUR RESPONSIBILITY TO KNOW IF YOUR PROVIDER IS CONTRACTED WITH YOUR INSURANCE.

THE VALANCE ON YOUR ACCOUNT PENDING INSURANCE PAYMENT IS YOUR RESPONSIBILITY. WE ASK THAT YOU BE PRO-ACTIVE WITH YOUR INSURANCE CARRIER AND MAKE ANY APPROPRIATE CALLS NECESSARY TO INSURE PROMPT PAYMENT OF YOUR CLAIMS.

COLLECTIONS

IF YOUR ACCOUNT BECOMES DELINQUENT OR OVER 90 DAYS OLD AND YOU FAIL TO MAKE PAYMENTS ON THAT ACCOUNT, IT WILL BE TURNED OVER TO CREDIT SYSTEMS INTERNATIONAL FOR

COLLECTION. IT IS BENEFICIAL FOR YOU TO TAKE CARE OF YOUR ACCOUNT BEFORE THIS HAPPENS TO INSURE YOUR GOOD CREDIT.

OUR BILLING OFFICE WILL WORK WITH YOU IN ANY REASONABLE WAY TO HELP YOU AVOID THIS SITUATION.

CANCELLATION AND NO SHOW POLICY

EFFECTIVE 8/1/2016, PATIENTS WHO DO NOT SHOW UP FOR THEIR APPOINTMENT WITHOUT A 24 HOUR CANCELLATION WILL BE CONSIDERED AS A NO SHOW AND WILL BE CHARGED A $25.00 NO SHOW FEE. THE NO SHOW FEE IS THE SOLE RESPONSIBILITY OF THE PATIENT AND MUST BE PAID IN FULL BEFORE THE PATIENTS NEXT APPOINTMENT. WE UNDERSTAND THAT SPECIAL UNAVOIDABLE CIRCUMSTANCES MAY CAUSE YOU TO CANCEL WITHOUT A 24 HOUR NOTICE. IN THIS INSTANCE, FEES MAY BE WAIVED BUT ONLY WITH MANAGEMENT APPROVAL.

SIGNATURE_____ DATE _____