Rockwall Rapid Care
2313 Ridge Road, Suite 105A
Rockwall, TX 75087
Office: (469) 769-5688 Fax: (469) 698-8686

Patient Intake Form

Reason for visit today?

_____

_____

_____

First Name:	
Middle Name:	
Last Name:	
Phone Number:	
Home Address:	
City:	
State:	
Zip Code:	
Date of Birth:	
Sex:	
Ethnicity (Hispanic, Non-Hispanic):	
Race (White, Asian, Black, Other):	
Parent / Guardian Full Name:	
Parent / Guardian Date of Birth:	
Email Address:	
Primary Care Provider Name:	

Medical History Intake Form

Patient Name _____

Chronic Medical Problems

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Medications

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Previous Surgeries

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Medication Allergies

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Family Health Problems

_____

_____

_____

_____

_____

_____

_____

Social History

Tobacco Use: Yes No Quit

Alcohol Use: Yes No Quit

Illicit Drug Use: Yes _____ No

Occupation: _____

Single Married Divorced Widowed

Consent to Treat & Financial Responsibility

I hereby authorize employees and agents of Rockwall Rapid Care (including physicians, physician assistants and nurse practitioners and other employees and staff members) to render medical evaluations and care to the patient indicated. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

Financial Responsibility Consent to Treat

I hereby authorize payment of medical benefits directly to Rockwall Rapid Care (hereinafter "RRC") and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to RRC. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of RRC, if any. The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

Acknowledgement of Receipt of Privacy Practices Notice

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care. RRC is furnishing you with the attached notice, which provides information about how RRC and its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. By signing this form, you acknowledge that you have received a copy of RRC's Notice of Health Information Practices.

Acknowledgement of Contact Methods

Note that for safety and convenience of patients, we require acceptance of practice interaction with patients through email, voicemail, and text in order for you to be a patient. This includes personal and health information to the patient and referring medical practices.

Method for contact

- X I acknowledge and authorize that my email address will be used to contact me and referring physicians about information for this visit
- X I acknowledge and authorize that my cellphone voice and voicemail will be used to contact me and referring physicians about information for this visit
- X I acknowledge and authorize that my cellphone text will be used to contact me and referring physicians about information for this visit

_____ _____

Patient Name (please print) **Signature of Patient, Parent, or Legal Guardian**