1800 Garner Field Road • Uvalde, TX 78801 • PH (830) 278-4453 • FAX (830) 278-3427

New Patient Application

Please fill all the information completely, return back to UFPA or fax to 830-278-3427

Jane D. Champion, PhD, DNP, FNP Cecilia Jo Murillo, M.D. Julia Rodriguez, APRN-FNP-BC

Date: _____

Name of Patient: _____ Date of Birth: _____

☐ Male ☐Female Telephone Number: _____

Mailing Address: _____

Previous Doctor(s): _____

Nature of Problem(s): _____

_____

Pregnant: ☐Yes ☐No If yes, how far along? _____

Insurance: _____

Policy # _____ Group# _____

Secondary Insurance: _____

Policy # _____ Group# _____

☐ Copy of Insurance Card(s) required
☐ Copy of Shot Record required for patients <21 years of age
☐ List of Medication(s) required

Are you related to anyone being seen in the practice? _____

For New Patient Children Applications Only:
☐ I do agree to vaccinate my child according to CDC recommendations.
☐ I refuse to vaccinate my child according to CDC recommendations.

For Office Use Only

☐ **Medical Records Requested** ☐ **Medical Records Received**
☐ **Medication List Completed** ☐ **Shot Record Provided** ☐ **Copy of Insurance Card(s)**

Accepted: _____ Declined: _____ Date Notified: _____
Comments: _____
Physician Signature: _____ Date: _____

Patient Information	
Name:	Date of Birth:

Medication List					
Medication	Dosage	Starting Date	Ending Date	Side Effects	Prescribed by:

Over-the-counter medications and vitamins: _____

_____

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Authorization Form
For Release of Protected Health Information

By signing this form, I authorize you to use and disclose the protected health information described below:

Patients Name: _____ Date of Birth: _____

The health information you may release subject to this authorization is as follows:

_____

Release my protected health information to the following entity:

Uvalde Family Practice Association
1800 Garner Field Road
Uvalde, Texas 78801
Fax Number: (830) 278-3427

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

_____

This authorization shall be in force and effective until the following event and/or date: _____

Name of Facility/Physician Name _____

Phone number _____ Fax Number _____

I understand that I have the right to revoke this authorization in writing, at any time by sending a written notification to the following:

Uvalde Family Practice Association

I understand that the revocation is not effective to the extent that the practice has relied on this authorization in its action. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself. I understand that information is used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPPA privacy regulations. The practice will not condition my treatment, payment and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative Description of Personal Representative's Authority