

FHP Geriatrics Registration Form Update Oct 2025

Even faster and to provide more details, skip the paper, visit fhpgeriatrics.com > New Patient



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Tomball, TX 77375 www.fhpgeriatrics.com

Fax: 888-840-6973
Email: admin@fhpgeriatrics.com

Patient Name: _____ Male: _____ Female: _____ Marital Status: _____

Name/Location of Facility: _____ Room/Unit # _____ Referred by _____

Billing Address: _____ City: _____ State: _____ Zip: _____

S.S. #: _____ Birth Date: _____ Ethnicity: _____

Power of Attorney Name _____ Relation: _____ Phone: _____

Main Contact Name _____ Relation: _____ Phone: _____

Main Contact E-mail: _____ Other Permitted Contacts: _____

Primary Insurance Policy: ***We must keep photo of the cards, and patient's driver's license on file - Please take a picture and text to 832-356-7878, or HIPAA secure email admin@fhpgeriatrics.com***

Is the insured a patient? ___ Yes Or ___ No Patient's relation to the insured: ___ Self ___ Spouse ___ other

Insurance Name: _____ Name of Insured: _____

Insured's Date of Birth: _____ Insured's ID #: _____ Group #: _____

Secondary Insurance: Insurance Name: _____ Name of Insured: _____

Insured's ID #: _____ Group #: _____

HIPAA Consent and Acknowledgment: Notice of Privacy Practices. I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

Assignment of Benefit: Please read and sign to have our office file your insurance: I authorize the release of information and understand that I am responsible for all costs of medical treatment. I hereby authorize payment directly to George Valdez, MD of the insurance benefits otherwise payable to me.

Treatment Policy: We collect estimated insurance portions at each visit. Your insurance contract is between you and your insurer, and you're responsible for unpaid balances regardless of estimated benefits. As a courtesy, we file claims for you. Payments typically arrive within 30-45 days; any balance after 60 days is due from you. All deductibles and co-pays are due at each visit. A copy of your insurance card will be kept on file. By signing, you consent to services in person or via our secure telehealth platform. Patients with chronic conditions may be enrolled in Chronic Care Management and Remote Patient Monitoring to track vitals, improve care, and prevent complications. You may opt out anytime, though participation supports better outcomes. A care plan covering your conditions, goals, interventions, and medications is created and available for review. AI technology is incorporated for quality control, data analysis, and documentation efficiency, not for clinical judgement. We can address general insurance questions, but for coverage details contact your insurer. If your insurance changes, update our office. **Most plans require deductible payments at the start of each year. Signed consent is required to schedule the first visit.**

____ DPOA ____ Patient Signature: _____ Date: _____

Medical Information

If prior records are available, print to pdf and send to our secure email: admin@fhpgeriatrics.com

Describe briefly, current active concerns:

Hospitalizations in last year (include where, when, & for what reason):

Please list the names of other providers *currently* seeing, type of specialty, and issues they are addressing:

PATIENT'S DIRECTIVES: How aggressively **the patient** would like us to approach care (we reassess regularly)

___(1) Possible hospice: poor quality of life: consider therapy, tests, meds, specialist referrals, **no hospital**.

If declines further, hospital unlikely to help, likely to cause more stress, consider hospice if no improvement.

___(2) Palliative: stable but fragile, consider therapy, tests, meds, specialists referrals as needed, but

Prefer **no hospital**, even for non-aggressive treatment (may need ER stabilization if acute issue after hours)

___(3) Nonaggressive: If needed, ok go to hospital, treat things easy to treat, but no aggressive measures

___(4) Somewhat aggressive: ok go to hospital, ventilator while awaiting prognosis, **no CPR** (shock, compressions)

___(5) Full, aggressive treatment to include ventilator and **CPR** (heart shock, compressions) if needed

Preference can always be changed, but it is helpful to have basic understanding before an emergency arises.

If a patient is not on hospice, and condition declines after hours, sending them to emergency room is default plan.

Code Status: ☐ DNR on file ☐ DNR requested ☐ Full Code

PAST MEDICAL HISTORY

Does the patient now or has ever had:

☐ High blood pressure

☐ High cholesterol

☐ Heart Failure CHF

☐ Coronary Artery Disease / Bypass / Stents

☐ CVA / TIA / Stroke

☐ Atrial Fibrillation: Occasional / Constant

☐ Asthma

☐ COPD / Emphysema / Chronic Bronchitis

☐ Arthritis

☐ Anemia

☐ Osteoporosis

☐ Low Thyroid

☐ Diabetes

☐ Kidney Disease / CKD

☐ BPH (Prostate Problem)

☐ Cancer (type) _____

☐ Dementia

☐ Depression

☐ Hip Fracture: L or R

☐ Seizures

☐ Cataracts

☐ Glaucoma

☐ Macular Degeneration

Other Conditions, Surgical History (Please List, online form will allow more details if needed)

● IN THE PAST MONTH, HAS THE PATIENT HAD ANY OTHER EVENTS, NEW OR WORSE SYMPTOMS OR PROBLEMS?

● IF KNOWN, WHEN WERE LAST YEARLY LABS (THYROID, CHOLESTEROL, ETC)? ANY UNSTABLE ISSUES?

DRUG ALLERGIES: ☐ No ☐ Yes To what?

CURRENT MEDICATION LIST- TAKE A PICTURE AND TEXT TO 832-356-7878, OR EMAIL ADMIN@FHPGERIATRICS.COM

THE FACILITY MAY HAVE ON FILE, BUT MAY BE UNAVAILABLE, AND WE MAY PLAN MORE EFFECTIVELY PRIOR TO FIRST VISIT

● CIRCLE IF SEEN IN THE LAST YEAR: CARDIOLOGIST EYE SPECIALIST DERMATOLOGIST DENTIST

● CIRCLE WHICH VISITING SPECIALIST YOU MAY NEED (IN PERSON OR THROUGH VIDEO VISIT, IF AVAILABLE)

CARDIOLOGY (HEART)

RHEUMATOLOGY (ARTHRITIS)

PSYCHIATRY

WOUND CARE

DENTIST

GENERAL SURGERY

OPHTHALMOLOGY (EYE)

NEPHROLOGY (KIDNEY)

ENDOCRINOLOGY (HORMONES)

INFECTIOUS DISEASE

PODIATRY (FOOT)

PULMONOLOGY/ SLEEP

DERMATOLOGY (SKIN)

NEUROLOGY

ONCOLOGY (BLOOD, CANCER)

PAIN REHAB

AUDIOLOGY (HEARING)

INTEGRATIVE / ACUPUNCTURE