Houston Family Physicians PA

Patient Information

Last Name	First Name	Middle Name	
Address	City	State	Zip Code
Home Phone	Cellular Phone (Optional)	Email Do Not Email □	

Marital Status: Single □ Married □ Divorced □ Widowed □ Separated □

Driver License #	Business owner □ Employed □ Unemployed □ Student □		
Date of Birth	Sex M □ F□	Primary Insurance	Insurance number Social Security Number
Spouse's Name	Contact Number	Occupation	
In Case of Emergency, Notify	Contact Number	Relationship	

Employment

Work Name	Work Number	Occupation	
Address	City	State	Zip Code

Responsible Party (Guarantor)

Last Name			
Address	First Name	Middle Name	
Home Phone	City	State	Zip Code

Relationship to Patient: S- self H- husband W- wife C- child P- parent O-other (please specify):

Social Security number	Date of birth	

How did you hear about us?

Was the Injury Work Related?	Date of Injury	Was the Injury Result of Accident?	Date of Accident

Consent for Treatment

I voluntarily consent and authorize Houston Family Physicians to provide me and my dependents with medical care and perform diagnostic tests.

Consent for Minor Child:

The undersigned hereby requests and authorizes Outpatient Clinical Care to perform diagnostic tests and render treatment to the patient, a minor child. This authorization extends to all other clinics, doctors. and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of the date below, the undersigned states and vows to have the legal right to select and authorize health care services for the minor child named above.

If applicable, under the terms and conditions of divorce, separation or other legal authorization, the consent of a spouse, former spouse, or other parent is not required. If authority to select and authorize this care should be revoked or modified in any way, the undersigned does hereby agree to notify the Houston Family Physicians PA. as soon as is possible.

Financial Responsibility and Assignment of Benefits:

All professional services rendered are charged to the patient and are due at the time of services, unless other arrangements have been made in advance with our practice financial advisor. Necessary form will be completed to help expedite insurance carrier payments. However, I am responsible for all fees, regardless of insurance coverage.

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan to issue payment check(s) to Houston Family Physicians P.A. for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any.

I hereby authorize Houston Family Physicians P.A. to release any information necessary concerning my illness and treatments, to process my insurance claim, and to allow photocopy of my signature to be used to process my insurance claim for the period of life time.

The insurance information furnished here represent a fully disclosure of the insurance/third party benefit to which I am entitled. I understand that failure to disclose precertification/second opinion requirements for any and all plans to which I subscribe, may cause to incur full liability for professional charges, as a result of non-payment by any carrier,

Would you like information on a Living Will? _____Yes _____No

Signature:_____ Date:

Confidentiality Questionnaire

People that we may inform about your general medical condition and your diagnosis:

□ Spouse □ Children □ Parents □ Any relative □ Other (specify: _____)

IN AN EMERGENCY.

□ Spouse □ Children □ Parents □ Any relative □ Other (specify: _____)

Preferred mailing address.

□ Home □ Other-specify: Street_____ City_____ Zip Code _____

Do you want all correspondence from our office sent in a sealed envelope marked " **CONFIDENTIAL"?**

□ Yes □ No

Preferred telephone number for lab results and other communication.

□ Home □ Other-specify: ( ) _____

Can we leave confidential information on your voicemail?

Home □ Yes □ No
Office □ Yes □ No

Signature:_____ Date:

INITIAL MEDICAL HISTORY: PLEASE COMPLETE. ALL ANSWERS CONFIDENTIAL

Name:		Age:		Date:	
Reason for visit:					
Allergies:					

Medications: (include vitamins and over-the-counter medications)

name	dosage	frequency	name	dosage	frequency

Past Medical History (circle only those diagnosed by a doctor)

0	NONE	23	Asthma	46	Diverticulosis	69	Chronic sinus infection
1	Stroke	24	COPD/emphysema/ch bronch	47	Diverticulitis	70	Eczema
2	TIA (“mini stroke”)	25	Sleep apnea	48	Chronic constipation	71	Psoriasis
3	Seizure disorder	26	High blood pressure	49	Hemorrhoids	72	Acne
4	Tension headaches	27	Angina / coronary disease	50	Chronic kidney failure	73	Rosacea
5	Migraine headaches	28	Heart attack	51	Kidney stones	74	Osteoarthritis/Degen joints
6	Major Depression	29	Congestive heart failure (CHF)	52	Urinary incontinence	75	Rheumatoid arthritis
7	Bipolar Disorder	30	Aortic valve stenosis	53	Enlarged prostate	76	Lupus (SLE)
8	Anxiety Disorder	31	Mitral valve regurgitation	54	Erectile dysfunction	77	Osteoporosis
9	Attention Deficit Disorder /ADD	32	Mitral valve prolapse	55	Painful menstruation	78	HIV / AIDS
10	ADHD (with hyperactivity)	33	Benign heart murmur	56	Irregular menstruation	79	Tuberculosis (lung disease)
11	Mental Retardation	34	Peripheral vascular disease	57	Heavy menstruation	80	Herpes
12	Developmental Delay	35	Esophagitis	58	Polycystic ovaries	81	Gonorrhea
13	Autism	36	Acid Reflux	59	Diabetes mellitus type 1	82	Chlamydia
14	Dementia	37	Hiatal Hernia	60	Diabetes mellitus type 2	83	Syphilis
15	Parkinson’s disease	38	Gastritis	61	High cholesterol	84	Mumps
16	Essential tremor	39	Stomach ulcers	62	Hyper (high) thyroid	85	Measles
17	Tinnitus	40	Fatty liver	63	Hypo (low) thyroid	86	Rubella
18	Peripheral neuropathy	41	Hepatitis	64	Obesity	87	Polio
19	Cataract	42	Gallstones	65	Anemia	88	Tetanus
20	Glaucoma	43	Irritable bowel syndrome	66	Cancer of:_____	89	Rheumatic fever
21	Macular degeneration	44	Crohn’s disease	67	Nasal allergies	90	Chicken pox
22	Retinopathy	45	Ulcerative colitis	68	Recurrent ear infections	91	Other? _____

Past Surgical History (provide approximate dates)

□ none	□ stomach surgery for obesity	□ removal of uterus and ovaries
□ carotid artery surgery	□ removal of gallbladder	□ repair of hip fracture
□ thyroid surgery	□ removal of appendix	□ hip replacement
□ coronary artery bypass surgery	□ removal of uterus (ovaries still in)	□ other:

Family History (provide approximate age of diagnosis, if known)

	Father	Mother	Children	Siblings	Grandpt		Father	Mother	Children	Siblings	Grandpt
□ None											
Breast Cancer	A1	A2	A3	A4	A5	Mental Illness	J1	J2	J3	J4	J5
Cervix Cancer	B1	B2	B3	B4	B5	Migraines	K1	K2	K3	K4	K5
Colon Cancer	C1	C2	C3	C4	C5	Alcoholism	L1	L2	L3	L4	L5
Other Cancer	D1	D2	D3	D4	D5	Asthma	M1	M2	M3	M4	M5
Heart attack or heart vessel disease	E1	E2	E3	E4	E5	Congestive heart failure (CHF)	N1	N2	N3	N4	N5
Stroke	F1	F2	F3	F4	F5	Liver failure	O1	O2	O3	O4	O5
Diabetes	G1	G2	G3	G4	G5	Kidney failure	P1	P2	P3	P4	P5
High BP	H1	H2	H3	H4	H5	List others:	Q1	Q2	Q3	Q4	Q5
Cholesterol	I1	I2	I3	I4	I5	List others	R1	R2	R3	R4	R5

Social History and Habits

Marital status: *Single Engaged Married Widowed Divorced Separated*

Number of children:_____

Occupation: _____ Retired

Dietary Restrictions (circle): *None*
Low salt Low cholesterol / fat Low sugar
No meat No dairy Other:(specify) _____

Exercise (circle): none sedentary occasional regular

Specify exercise:_____

Sexually active? (circle): *yes no single partner multiple partners*

Always use a condom? *yes no*

Birth control (circle): *pills depo injection patc h condom IUD*

Caffeine: #_____cups/day

Smoke: #_____packs/day since age: ____

Alcohol: #_____ ounces/week

Recreational drug use (circle): *yes no*

If yes, what kind? _____

Health Maintenance

Last Cholesterol screening: _____

Last Tetanus vaccination (year): _____

Last Flu shot (month &year): _____

Last Pneumonia shot (year): _____

Hepatitis B vaccination? (circle) Yes (year?):_____ No

Tuberculosis skin test? (circle) Yes (year & result): No _____

Last eye doctor appointment (month & year): _____

Last dentist appointment (month & year): _____

(age > 65) Bone Density Scan? (year): _____

(age > 50) Last colon cancer screening (year): _____

Male : Last digital rectal prostate exam

Last PSA for prostate cancer screen _____

Female: Last Pap smear: (month & year)

Last Mammogram: (month & year) _____