



PATIENT INFORMATION FORM Page 1

LAST NAME	FIRST	MIDDLE	DATE OF BIRTH	AGE	SEX	SOCIAL SECURITY NUMBER	
STREET ADDRESS Circle whether PERMANENT or TEMPORARY			CITY	STATE	ZIP	HOME PHONE - INCLUDE AREA CODE ()	
PATIENT'S OCCUPATION		Circle whether RIGHT LEFT HANDED	NAME OF EMPLOYER (OR SCHOOL)		MARITAL STATUS D - S - M - W - SEP		
EMPLOYER'S ADDRESS			CITY	STATE	ZIP	EMPLOYER PHONE - INCLUDE AREA CODE ()	
SPOUSE'S NAME		SPOUSE'S ADDRESS (If different from patient)			SPOUSE PHONE - INCLUDE AREA CODE ()		
SPOUSE'S EMPLOYERS NAME, ADDRESS, CITY, STATE, ZIP				SPOUSE'S SOCIAL SECURITY NUMBER		SPOUSE EMPLOYER PHONE ()	
PERSON TO CALL IN CASE OF EMERGENCY		RELATIONSHIP TO PATIENT		HOME PHONE ()		BUSINESS PHONE ()	
YOUR EMAIL ADDRESS (NO CONFIDENTIAL PATIENT INFORMATION WILL GO THROUGH EMAIL)							
ALL STUDENTS AND/OR MINORS (UNDER 18) MUST FILL IN SECTION BELOW							
MOTHER'S NAME <input type="checkbox"/> CHECK IF RESPONSIBLE FOR PAYMENT			STREET ADDRESS, CITY, STATE, ZIP			HOME PHONE ()	
MOTHER'S EMPLOYER'S NAME, ADDRESS, CITY, STATE, ZIP				MOTHER'S SOCIAL SEC.		MOTHER'S EMPLOYER PHONE ()	
FATHER'S NAME <input type="checkbox"/> CHECK IF RESPONSIBLE FOR PAYMENT			STREET ADDRESS, CITY, STATE, ZIP			HOME PHONE ()	
FATHER'S EMPLOYER'S NAME, ADDRESS, CITY, STATE, ZIP				FATHER'S SOCIAL SEC.		FATHER'S EMPLOYER PHONE ()	
ALL PATIENTS MUST COMPLETE INFORMATION BELOW							
DESCRIBE ILLNESS OR INJURY: (If injury, describe how occurred.)			TYPE OF ACCIDENT AUTO FALL WORK OTHER		IF FALL - WHERE DID YOU FALL?		DATE OF ACCIDENT/ONSET
Patient TREATED at or REFERRED by any of the following for current problem? (Circle all that apply)		HOSPITAL (IN-PATIENT)	EMERG ROOM	"WALK-IN" FACILITY	PRIMARY CARE DR.	OTHER	
NAME OF YOUR FAMILY/REFERRING DOCTOR		YOUR DOCTORS ADDRESS				YOUR DOCTORS TELEPHONE # ()	
YOUR INSURANCE INFORMATION - ALL PATIENTS MUST COMPLETE							
DRAW ONE CIRCLE AROUND PRIMARY INSURANCE CARRIER		MEDICARE	HMO	PPO	TEXAN PLUS	NONE DEPENDENT CHILD COVERED BY: Circle which): 1 or 2 parents	
PRIMARY CARRIER (NAME, SEND CLAIMS TO ADDRESS)							
PRIMARY INSURANCE ID#:			GROUP NUMBER:				
NAME OF POLICY HOLDER:		DATE OF BIRTH:		SOCIAL SECURITY NUMBER		PATIENT'S RELATIONSHIP TO INSURED:(Circle which) SELF SPOUSE CHILD OTHER	
ADDRESS OF POLICY HOLDER			CITY		STATE	TELEPHONE (INCLUDING AREA CODE) ()	
SECONDARY CARRIER (NAME, SEND CLAIMS TO ADDRESS)							
SECONDARY INSURANCE ID#:			GROUP NUMBER:		POLICY HOLDER NAME:		DATE OF BIRTH
PARENTS/GUARDIANS: I HEARBY GIVE PERMISSION TO THE PHYSICIANS OF Memorial Clinical Associates, P.A. , TO EXAMINE AND TREAT MY MINOR CHILD. SIGNED:						NAME (PRINTED):	
TODAY'S METHOD OF PAYMENT (Required; please circle which) CASH - CHECK - CREDIT CARD						DRIVER'S LICENSE NUMBER	
PREVIOUS PATIENT YES NO		IF YOU HAVE BEEN A PREVIOUS PATIENT, WHICH DOCTORS HAVE YOU SEEN? Hitchins Franco Jefferies Hughart Levins Pohil Gidvani Schultz Tenaro Hodge Smith			HOW DID YOU HEAR OF OUR PRACTICE?		
FORM UPDATED Monday, January 17, 2005							



FINANCIAL RESPONSIBILITY

Thank you for choosing a **MEMORIAL CLINICAL ASSOCIATES, P.A.** physician as your health care provider. We are committed to your satisfaction. Please assist us in meeting your expectations by reviewing the Financial Policy below. The following are the financial policies and guidelines for Memorial Clinical Associates. Please read carefully before signing and do not hesitate to ask any questions you may have.

FORMS:

You will be asked to complete a registration form, which will include your home address, telephone number, social security number as well as the address and telephone number of your insurance company, if applicable. Insurance Company information can generally be obtained from a card provided to the company's insured member, and we make a copy of the card for our records. We also request a copy of your driver's license or other picture identification to include in your record to insure accuracy of your medical records.

FORMS OF PAYMENT:

For your convenience, we accept cash and checks, as well as many credit cards. We must have a copy of your driver's license to accept checks.

OFFICE VISITS:

All office charges are payable at the time the service is rendered. For your convenience, we will provide you with a receipt, documenting the charges for your visit, which you may use to file for reimbursement with your insurance carrier and/or secondary insurance.

Memorial Clinical Associates, P.A. participate in many managed care plans and will be happy to submit insurance claims to your primary insurance company.

As a courtesy, however, the patient will be responsible for filing to their secondary insurance. **Any co-payment, co-insurance percentage, deductibles for which you are responsible or co-payments that cannot be billed to patient, must be paid at the time of service.** It is your responsibility, before the physician you will be seeing renders services, to make sure your insurance covers the services provided.

Please be prepared to show your insurance card and driver license on your initial visit. We are required by insurance companies to verify insurance at each visit therefore please be prepared to show your insurance card at each visit **(if a patient ever has any insurance change, it is the patient's responsibility to provide the new information and insurance card).** **If this information is not provided BEFORE the visit, the patient will be responsible for the charges incurred for any dates of service prior to the new information being given.**

Some insurance companies do not cover all services performed in our office (i.e. Preventive care, routine exams, immunizations, etc...) The patient is therefore responsible for charges denied by their insurance as "not a covered benefit". If you have met your deductible please bring proof of meeting your deductible. Please let us know when you call to make an appointment of any changes in your insurance coverage or plan. It will be your responsibility to make payment for any service not covered by your insurance company. If benefits and eligibility cannot be verified prior to service, you will be required to pay for service in full. Any charges denied by your insurance carrier would be your responsibility.

FINANCIAL RESPONSIBILITY FOR MINORS

Unless prior arrangements have been made, charges for a minor child seen in the office will be the responsibility of the adult accompanying the minor child.

HOSPITAL FEES

If you are responsible for your doctors fees while in the hospital, payment arrangements may be made by calling our Business Office at (713) 407-3051 or FAX us at (713) 407-3089. In the event you have insurance for hospitalization, all fees for hospital services will be filed with your insurance company upon discharge from the hospital. Any deductible or co-payment will be due when invoiced by **Memorial Clinical Associates, P.A.**

QUESTIONS

If you have any questions concerning charges, filing insurance claims, or billing please call our Business Office at (713) 407-3051 or FAX your questions to (713) 407-3089.

I authorize **Memorial Clinical Associates, P.A.** to file my medical claims to my insurance, and release medical information necessary to process any claim. I authorize payment of medical benefits **to Memorial Clinical Associates, P.A.** I assume responsibility for payment of my account.

I have read and understand the above policies of **Memorial Clinical Associates, P.A.** and by signing below I agree to the above stated terms.

I, the Guarantor, have read and agree to the terms regarding payments and payment responsibility.

Signature: _____ **Date:** _____

Print Name: _____ **Chart Number:** _____

(To be completed by office)

Witness Name(Print): _____

INSURANCE FINANCIAL RESPONSIBILITY

I understand that my primary will be filed, and if no payment is made within 45 days, I will be responsible for the balance.

Signature

I hereby authorize the clinic, as a holder of medical information, to release to my insurance carrier or its intermediaries any information needed for this or future related claim(s). I further request payment be made **to Memorial Clinical Associates, P.A.**, and authorize the clinic to submit claims on my behalf for any bills or services furnished to me. I understand that by filing claims for me as the patient, **Memorial Clinical Associates, P.A.** is performing a service, not a claim requirement by law.

I hereby acknowledge and understand that I am financially responsible for any portion of my bill not covered by my insurance carrier.

If this account is placed in the hands of a collector or an attorney for collection, reasonable cost of collection including attorney fees will be paid by the undersigned.

Date

Signature

First Date of Service _____

Patient Name _____

Home Phone () _____ Work Phone () _____

Nearest Relative (outside of home) _____ Phone () _____

This document represents an agreement between **MEMORIAL CLINICAL ASSOCIATES, P.A.** and the undersigned. If you have insurance, we will file your claim as a service to you. In the event your insurance does not pay the expected amount, you will be responsible for any remaining balance on your account, in addition to the amount required at the time of service.

Patient's or Responsible Party's Signature

Witness Signature



Memorial Clinical Associates

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that part of the provision of healthcare services, *Memorial Clinical Associates*, creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization deserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that *Memorial Clinical Associates* and I must:
 - a. agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and
 - b. agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agree upon.

 (PATIENT'S NAME PRINTED)

 DATE

 PATIENT'S SIGNATURE (OR GUARDIAN, IF MINOR)

 SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)

 WITNESS (OPTIONAL)

 DATE



This information will allow us to contact you in regards to all medical results, inquiries and office/medical related issues.

Please list telephone numbers that we may use to contact you:

1. _____ (Home - Work - Cell - Other: _____)
2. _____ (Home - Work - Cell - Other: _____)
3. _____ (Home - Work - Cell - Other: _____)

In the event Memorial Clinical's associates are unable to reach you concerning your issues related to this office and/or your treatment, may we leave a message on:

- | | | |
|----------------------------|-----------|----------|
| 1. Home Answering Machine? | YES _____ | NO _____ |
| 2. Work Voice Mail? | YES _____ | NO _____ |
| 3. Cellular Voice Mail? | YES _____ | NO _____ |

If you have provided a work telephone number for us to contact you, and you are unavailable, may we leave a message with your receptionist/operator to have you return the office's call? YES _____ NO _____

Please list the names of any person(s) to whom you give us permission to discuss anything concerning your medical status (i.e.: relative, spouse, friend.)

IF THE NAME IS NOT LISTED, WE WILL NOT DISCUSS OR RELEASE ANY INFORMATION

Name: _____ Name: _____

Name: _____ Name: _____

Patient Name: _____ Date: _____

Signature: _____ Relationship (if not patient): _____

THIS DOCUMENT WILL EXPIRE 1 YEAR FROM SIGNATURE DATE



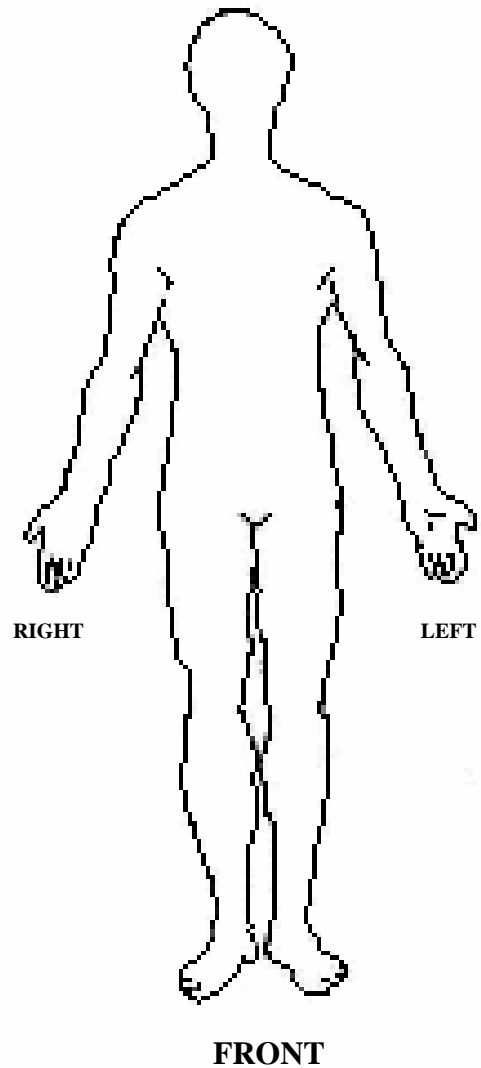
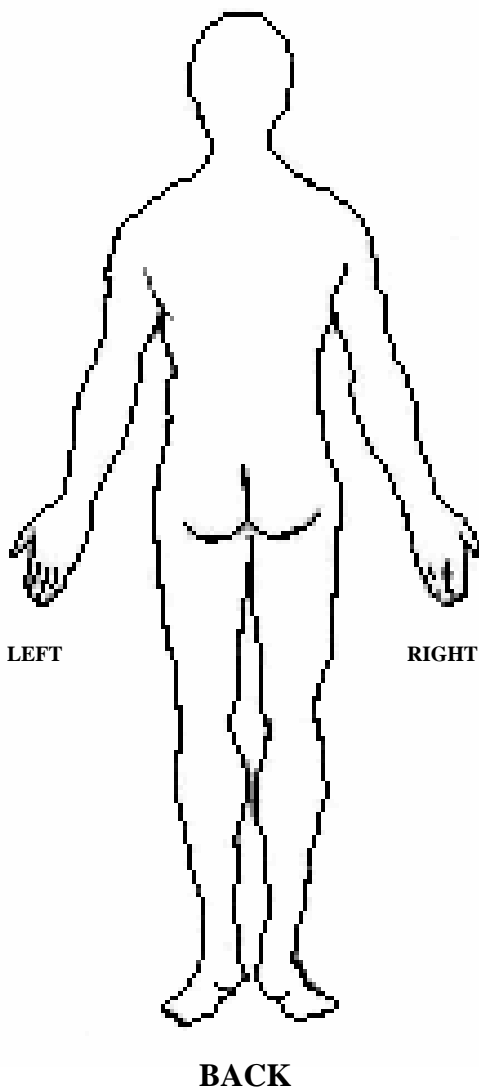
Name: _____

Date: _____

Using the symbols shown below, mark the area on your body where you feel the described sensations.
Include all affected areas. Just to complete the picture, please draw your face.

Aching ^ ^ ^	Numbness = = =	Pins & Needles O O O	Burning X X X	Stabbing / / /	Other + + +
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If you are experiencing symptoms other than what is listed, please describe your symptoms:





Today's Date: _____

GENERAL

HAVE YOU EVER SMOKED CIGARETTES? YES OR NO, WHAT TYPE AND HOW LONG? _____

DO YOU DRINK ALCOHOL? YES OR NO, WHAT TYPE AND HOW OFTEN? _____

DO YOU USE DRUGS (MARIJUANA, COCAINE, ETC.)? _____

WEIGHT LOSS OR GAIN? _____ WEAKNESS: _____ FATIGUE: _____ FEVER: _____

WHEN WAS YOUR LAST PHYSICAL EXAMINATION? _____

HOW MUCH CAFFEINE (COFFEE, TEA, COLA) DO YOU DRINK PER DAY? _____

HAVE YOU EVER HAD YOUR CHOLESTEROL CHECKED? _____ WHEN/WHAT LEVEL: _____

HAVE YOU EVER HAD YOUR STOOL CHECKED FOR BLOOD? _____ WAS IT POSITIVE? _____

SKIN

RASH: LUMP: SORES: ITCH OR DRY: HAIL OR NAIL CHANGES:

HEAD

HEADACHES: HOW OFTEN? _____

EYES

BLURRY VISION: PAIN: REDNESS:

EARS

RINGING: DIZZINESS: PAIN:

NOSE AND SINUSES

BLEEDING: PAIN: SORE OR ULCER: HOARSENESS:

NECK

LUMP OR SWELLING: PAIN:

BREAST (FEMALE)

SELF EXAM MONTHLY: LUMP OR NODULE: NIPPLE DISCHARGE:

RESPIRATORY

COUGH: SPUTUM: COUGH UP BLOOD: WHEEZING: PAIN: SHORTNESS OF BREATH:

CARDIAC

DISCOMFORT: PRESSURE: PAIN: SHORTNESS OF BREATH:

GASTROINTESTINAL

SWALLOWING DIFFICULTIES: INDIGESTION: BOWEL HABIT CHANGES: DIARRHEA: CONSTIPATION:

ABDOMINAL PAIN: BLOATING: STOOL INCONTINENCE: NAUSEA/VOMITING:

MUSCULOSKELETAL

JOINT OR MUSCLE PAIN: JOINT STIFFNESS: BACK PAIN:

NEUROLOGY

FAINTING: BLACKOUTS: SEIZURES: WEAKNESS: PARALYSIS: NUMBNESS: TINGLING:

TREMORS: INVOLUNTARY MOVEMENT:

HEMATOLOGIC

EASY BLEEDING OR BRUISING: TRANSFUSION IN PAST:



ENDOCRINE

HEAT INTOLERANCE: COLD INTOLERANCE: EXCESSIVE SWEATING: EXCESSIVE THIRST:
EXCESSIVE HUNGER: FREQUENT URINATION:

URINARY

PAIN: INCREASED FREQUENCY: URINATE AT NIGHT: URGENCY: PAIN WITH THE URINATION:
BLEEDING: URINE INCONTINENCE:

PSYCHIATRIC

NERVOUSNESS: TENSION: MEMORY PROBLEMS: SLEEP DISTURBANCES: APPETITE PROBLEMS:

VASCULAR

LEG SWELLING: LEG PAIN OR CRAMPS:

FEMALE PATIENTS ONLY

AT WHAT AGE DID YOU BEGIN YOUR MENSTRUAL CYCLE? _____ ARE THEY REGULAR? YES OR NO

WHEN WAS YOUR LAST PERIOD? _____ FREQUENT MENSES: YES OR NO POSTMENOPAUSAL? YES OR NO

DO YOU USE BIRTH CONTROL? YES OR NO WHICH KIND? _____ HEAVY MENSES? YES OR NO

NONMENSTRUAL BLEEDING: BLEEDING W/INTERCOURSE: HYSTERECTOMY:

WHEN WAS YOUR LAST PAP SMEAR? _____ HAS IT EVER BEEN ABNORMAL? YES OR NO WHEN: _____

HAVE YOU EVER BEEN PREGNANT? YES OR NO HOW MANY TIMES? _____

HOW MANY LIVE BIRTHS HAVE YOU DELIVERED? _____

HOW MANY ABORTIONS OR MISCARRIAGES? _____

HAVE YOU EVER HAD A CAESAREAN SECTION? YES OR NO (IF SO, HOW MANY?) _____

MALE PATIENTS ONLY

DO YOU HAVE PROSTATE TROUBLE? YES OR NO

HAVE YOU EVER HAD A PROSTATE EXAM? YES OR NO

DO YOU EXAMINE YOUR TESTICLES FOR TUMORS? YES OR NO

HAVE YOU EVER BEEN TOLD YOU HAVE A HERNIA? YES OR NO

PENILE DISCHARGE: PENILE SORE OR ULCER: PAIN: HESITANCY: DRIBBLING:

DECREASE FORCE OF STREAM: