Northwest Houston Surgical Association

Dr. Ayyar Dr. Leiva Dr. Ziad Amr

Thank you for choosing our office. In order to serve you properly, we need the following information. Please print. All information will be confidential

PATIENT INFORMATION

PATIENT NAME : _____

BIRTHDATE : _____ **AGE** : _____ **GENDER** M/F : _____

MARITAL STATUS : _____ **SS#**_____

ADDRESS : _____**ZIP CODE** : _____

E-MAIL : _____

HOME PHONE : _____ **CELLULAR :** _____

EMPLOYER : _____ **WORK PHONE** : _____

EMPLOYER ADDRESS : _____

REASON FOR TODAY'S VISIT : _____

WHOM MAY WE THANK FOR REFERRING YOU? : _____

DR'S PHONE NUMBER : _____

PRIMARY CARE DR : _____ **PHONE :** _____

EMERGENCY CONTACT NAME AND NUMBER : _____

PARENT IF PATIENT IS A MINOR?

Do you give NHSA permission to obtain your medication history? (Y) (N)

Are you allergic to any medication (Y) (N) List: _____

DO YOU TAKE ANY BLOOD THINNERS?

ASPRIN / COUMIDIN / PALVIX / PRADAXA / XARELTO / ZEITA _____

List ALL Medications Below
IF YOU REQUIRE ADDITIONAL SPACE PLEASE ATTACH YOUR LIST
Including Over-the-Counter /Vitamins/Herbal Supplements

NAME OF MEDICATION	DOSE/ STRENGTH	FREQUESNCY / HOW MANY TIMES DAY	WHY DO YOU TAKE THIS MEDICATION	MD WHO PRESCRIBED	COMMENTS

Preferred Pharmacy Name: _____

Phone: _____ **Fax:** _____

MEDICAL QUESTIONARE

PATIENT MEDICAL HISTORY		FAMILY MEDICAL HISTORY
DIABETES (Y) (N) INSULIN OR NON-INSULIN	**ASTHMA** (Y) (N)	**DIABETES** NON-INSULIN (Y) (N) MOTHER OR FATHER
ALLERGIES (Y) (N)	**SKIN DISORDERS** (Y) (N)	ALLERGIES (Y) (N) MOTHER OR FATHER
HEART DISEASE (Y) (N)	**PSYCHRIATRIC DISORDERS** (Y) (N)	**HEART DISEASE** (Y) (N) MOTHER OR FATHER
HIGH BLOOD PRESSURE (Y) (N)	**THYROID TROUBLE** (Y) (N)	**HIGH BLOOD PRESSURE** (Y) (N) MOTHER OR FATHER
STROKE / EPILEPSY / CONVULSIONS (Y) (N)	**HIV** (Y) (N)	**STROKES/EPILEPSY/CONVULSIONS** (Y) (N) MOTHER OR FATHER
CANCER / TUMORS / GROWTH (Y) (N) Type	**OTHER / NONE** **HEIGHT**	**CANCER / TUMORS / GROWTH** (Y) (N) MOTHER OR FATHER
TUBERCULOSIS (Y) (N)	**WEIGHT**	**TUBERCULOSIS** (Y) (N) **MOTHER OR FATHER**
ULCERS/STOMACH PROBLEMS (Y) (N)	**SMOKE** (Y) (N) **HOW MUCH** **HOW LONG**	**ULCERS/STOMACH PROBLEMS** (Y) (N) MOTHER OR FATHER
MAJOR BODY INJURY (Y) (N)	**CAFFEINE** (Y) (N) **HOW MUCH** **HOW LONG**	**THYROID TROUBLE** (Y) (N) MOTHER OR FATHER
HEPATITIS / LIVER DISEASE (Y) (N)	**ALCOHOL** (Y) (N) **HOW MUCH** **HOW LONG**	**HEPATITIS / LIVER DISEASE** (Y) (N) MOTHER OR FATHER
KIDNEY/BLADDER INFECTIONS (Y) (N)	**ARE YOU PREGNANT?** (Y) (N)	**KIDNEY/BLADDER INFECTIONS** (Y) (N) MOTHER OR FATHER
TENDENCY TO EASILY BLEED (Y) (N)		**HIV** (Y) (N) MOTHER OR FATHER

LIST ANY PREVIOUS SURGERIES OR HOSPITILIZATIONS

_____ **Year** _____ _____ **Year** _____

_____ **Year** _____ _____ **Year** _____

_____ **Year** _____ _____ **Year** _____

INSURACE INFORMATION

*******If the patient has a HMO insurance, a referral from the PCP is required to allow the patient to be seen by our group. If the patient does not have a valid referral at the time of the appointment, we will offer to reschedule the appointment until a referral is obtained or see the patient on a self-pay basis.***

Primary Insurance: _____ **ID#** _____**Group#**_____

S**ubscriber's Name**_____ **Subscriber SS#**____/___/____**Subscriber Date of Birth**___/___/___

Subscriber's Employer: (□ same as above) _____**Work Phone:** _____

Claims Address: _____

Ins. Phone#_____ **Subscriber Relation to Patient:** _____

Secondary Insurance: _____**ID#**_____ **Group#**_____

Subscriber's Name_____ **Subscriber SS#**___/___/___**Subscriber Date of Birth**___/___/___

Subscriber's Employer: (□ same as above) _____**Work Phone:** _____

Claims Address: _____

Ins. Phone#_____ **Subscriber Relation to Patient:** _____

IS THIS A WORK RELATED INJURY? ____ IF YES, PLEASE PROVIDE FOLLOWING INFORMATION:

Claim Adjustor's Name: _____ **Phone**: _____ **Date of Injury**: _____

Claim Number: _____ Contact at Employer: _____ Contact's Phone: _____

I authorize release of any information concerning my (or my child's) health care, advice and treatment for the purpose of evaluating and treating, obtaining clinical information and results from previous physicians and or healthcare facilities. As well as administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the Physician.

_____ _____

Signature **Date**

NHSA Disclosure Acknowledgement

The undersigned certifies that He / She is the patient or is duly authorized by the patient as the patient's general agent to execute and accept these terms.

Date	**Patient, Patients Agent or Représentative**
Witness	**Relationship to Patient**

Acknowledgement of Review of
Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Date	**Signature of Patient or Personal Representative**
Name of Patient or Personal Representative	**Description of Personal Representative's Authority**

NHSA Financial Policy

I authorize release of any information concerning my (or my child's) health care, advice and treatment for the purpose of evaluating and treating, obtaining clinical information and results from previous physicians and or healthcare facilities. As well as administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the Physician.

Date	**Patient, Patients Agent or Représentative**
Witness	**Relationship to Patient**

Regarding Your Medication History

I authorize NHSA to access my patient medication history.

Date	**Patient, Patients Agent or Représentative**
Witness	**Relationship to Patient**