



PATIENT INFORMATION PACKET

Date: _____

We know paperwork is not fun, but thank you so much for taking the time!

Last Name: _____ First Name: _____ M.I. _____

Address: _____ Phone: _____

City _____ State: _____ Zip Code: _____ Mobile: _____

Date of Birth: ___/___/___ Social Security: ___-___-___ Email: _____

Gender ___ Marital Status: _____ Spouse Name: _____

Emergency Contact Name: _____ Phone: _____

Primary Care Physician: _____ Phone or Address: _____

Cardiologist: _____ Phone or Address: _____

Please Tell Us – How Did You Find Us?

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Doctor Referral (Dr. _____) | <input type="checkbox"/> Facebook | <input type="checkbox"/> Friend or Family | <input type="checkbox"/> Pearland's Best Coupon Book |
| <input type="checkbox"/> Google | <input type="checkbox"/> Our Website | <input type="checkbox"/> Magazine Ad | <input type="checkbox"/> Other Ad |
| <input type="checkbox"/> Mailed Postcard | <input type="checkbox"/> Event (ex: Senior Fest) | <input type="checkbox"/> E.R. Referral | <input type="checkbox"/> Drove by Our Office |
| <input type="checkbox"/> Phonebook | <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> Self Referred |

EMPLOYMENT INFORMATION

Employer Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Employment Status: (Check) Full Time Part Time Unemployed Retired Self Employed

INSURANCE INFORMATION

Please Check One

Self Pay? (No Insurance) Insured? (Have Insurance)

HEALTH HISTORY INFORMATION



Patient Name: _____ DOB: _____

Your Symptoms: Check all symptoms that apply to you – PLEASE read carefully!

What are you here to take care of today? _____

- | | | |
|---|---|--|
| <input type="checkbox"/> Weight Loss / Gain | <input type="checkbox"/> Excessive Salivation | <input type="checkbox"/> Palpitation of Heart |
| <input type="checkbox"/> Chills / Fevers | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Fatigue / Lack of Energy | <input type="checkbox"/> Fullness in Stomach | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Vomiting of Blood | <input type="checkbox"/> Abnormal Heart Rhythm |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Abdominal Cramps | <input type="checkbox"/> High Blood Pressure / Heart Issues |
| <input type="checkbox"/> Seizure | <input type="checkbox"/> Pain after eating | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Frequent Headache | <input type="checkbox"/> Constipation | <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Forgetfulness |
| <input type="checkbox"/> Production of Sputum | <input type="checkbox"/> Change of Stool Width/Diameter | <input type="checkbox"/> Unusual Early Morning Awakening |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Rectal Itching / Pain | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Hemorrhoid | <input type="checkbox"/> Incomplete Urination |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Painful Bowel Movement | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Itchy Skin | <input type="checkbox"/> Ribbon-Like Stool | <input type="checkbox"/> Problems with Kidney |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Diarrhea After Eating | <input type="checkbox"/> Diabetes / Blood Sugar Issues |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Visible Blood in Stool | <input type="checkbox"/> Mucus / Slime in Stool |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Incomplete Bowel Movement | <input type="checkbox"/> Dark / Tarry Stool |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Low Thyroid | <input type="checkbox"/> Abdominal Swelling |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Excessive Gas / Bloating |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Stiffness of Joints | <input type="checkbox"/> Dryness of Mouth |
| <input type="checkbox"/> Heart burn / Indigestion | <input type="checkbox"/> Excessive Burping | |
| | <input type="checkbox"/> Bad Breath | |
| | <input type="checkbox"/> Hoarseness of Voice | |

Very Important: Please answer Yes/No to the following

- Yes No
1. Have you ever had blood pressure / heart issues?
2. To the best of your knowledge, do you have any allergies to anything?
3. Have you ever had any operations during your life? Please explain below:
- _____
- _____
- _____

4. Please check if you take any medications, injections, or pills for the following:
- Heart Kidney Lungs Diabetes Eye Blood Pressure
5. Do you smoke? (If so, how many packs per day? _____)
6. Do you drink? (If so, how frequently? _____)

Please List Any Allergies you have:



MEDICAL RELEASE FORM

Patient: _____

Date of Birth: _____

Social Security #: _____

This paperwork is used so that we may obtain your medical records from your current or previous physician(s). You do have a right to decline signing this; however, if you agree with the checked items below, please sign so that we may receive medical history information from your other physicians.

Authorization Notice

This document authorizes you to provide a copy, summary, or narrative of my medical records as indicated by check mark(s) below or otherwise release any medically relevant confidential information.

- Complete record
- Records of care from the dates: _____ to _____
- Records of the following condition(s): _____
- Other (please specify): _____

HIV/AIDS: I hereby consent to release any positive or negative test results for HIV OR AIDS infection, antibodies for AIDS or infection with any other causative agent of AIDS with the rest of my medical records.

(x) Patient Signature: _____ Date: _____

Release to

This information may be released to the following person(s)/entity:

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> Dr. N. Meah | <input type="checkbox"/> Dr. U. Siddiqui | <input type="checkbox"/> YuEun Hwang, AGNP | <input type="checkbox"/> Hazel Aguda, FNP | <input type="checkbox"/> Shantele Johnson, NP |
| 109 Parking Way
Lake Jackson, TX 77566
Fax: (979) 292-0488 | 109 Parking Way
Lake Jackson, TX 77566
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Lake Jackson, TX 77566
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Lake Jackson, TX 77566
Fax: (979) 292-0488 | 109 Parking Way
Lake Jackson, TX 77566
Fax: (979) 292-0488 |

Family / Spouse: _____

Other (please fill in if relevant): _____

The reasons or purpose of this release of information are as follows: _____

Patient Signature: _____ Date: _____

I understand that you will provide this information within 15 days from receipt of request and that a fee for furnishing this information may be charged to the requesting patient according to rulings set forth by the Texas State Boards of Medical Examiners.



ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE

Patient Name: _____

Date: _____

Please Read and Check All Items

I have filled out the information package.

- I have received and reviewed my Patients Rights and Responsibilities package. This document discusses my rights as a patient.
- I have received and reviewed the Notice of Privacy Policies. This document discusses how my medical information will be used. I understand that it is my responsibility to provide this medical center with all necessary referrals.
- I have authorized this facility to receive payments of benefits for services rendered to me. Any medical information needed to determine the eligibility or payments of benefits to process my claim can be provided. I understand that some medical services that are deemed necessary by my physician may not be deemed necessary by my insurance company. In such cases, it is my responsibility to provide the payment. I understand that some of the services may or may not be in network.
- I give my permission for this facility to examine me and permit them to perform any necessary physical or lab test deemed necessary for my treatment.
- I have read and understand the notices observable in the patient areas.
- All patients will be evaluated and screened by a nurse practitioner (NP). I understand that Nurse Practitioner's are not doctors and are registered nurses with special advanced training that allows them to function on behalf of physicians. I understand that the NP will be overseen by my physician and I consent to the services of an NP as needed for my health care needs. We appreciate your understanding.**
- I understand that my email and other information may be used to send newsletters and other solicitations/updates from time to time from this entity or other affiliated entities.

By signing below, I acknowledge that I have received, reviewed, and understand the information read above.

Patient Signature: _____ **Date:** _____

Name of Legal Representative: _____

Relationship of Representative: _____



NO SHOW GUIDELINES

The purpose of the NO SHOW policy is to deliver optimal care in an environment of minimal risk, by ensuring continuity of care and appropriate follow ups for The GI Center patients that do not keep appointments. This policy places a greater emphasis on appointment confirmations.

The GI Center will attempt to contact you 48 hours PRIOR to your scheduled appointment to confirm your visit. If we are unable to speak with you and have to leave a message, you will need to contact the off BY NOON, the day BEFORE your appointment; otherwise, we reserve the right to cancel the appointment and mark you as a NO SHOW.

The GI Center will do our best to accommodate all of our patients. If your appointment was cancelled, you are welcome to reschedule to another date, or wait in the lobby for us to try and fit you in; however, there is no guarantee that you will be seen on that day.

NO SHOW is defined as:

1. Someone who misses an appointment without cancelling, or rescheduling by noon the day before your appointment; or
2. A failure to present at the time of a scheduled appointment. The NO SHOW will be recorded in the Electronic Health Record (HER), and you will be charged as follows:

\$100 for missed office visit.

\$200 for missed procedure.

I have read and understand the GI Center NO SHOW guidelines as described above.

Patient Name

Date