Patient Information Packet

Date/Fecha: _____

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

Last Name/Apellido: _____ **First Name/Nombre:** _____ **M.I./Inicial:** _____
Address/Dirección: _____ **Phone/Teléfono:** _____
City/Ciudad: _____ **State/Estado:** _____ **Zip Code/C.P.:** _____ **Mobile/Celular:** _____
DOB/Fecha de Nac.: _____ **SSN/Seguro Social:** _____ **Email/Correo:** _____
Gender/Género: _____ **Marital Status/Estado Civil:** _____ **Spouse/Cónyuge:** _____
Emergency Contact/Contacto de Emergencia: _____ **Phone/Teléfono:** _____
Primary Care Physician/Médico de Cabecera: _____ **Phone or Address/Teléfono o Dirección:** _____
Cardiologist/Cardiólogo: _____ **Phone or Address/Teléfono o Dirección:** _____

Please Tell Us - How Did You Find Us? / Díganos - ¿Cómo Nos Encontró?

☐ Doctor Referral (Dr._____)
☐ Facebook
☐ Friend or Family / Amigo o Familiar
☐ Pearland's Best Coupon Book
☐ Google
☐ Our Website / Nuestro Sitio Web
☐ Magazine Ad / Anuncio de Revista
☐ Other Ad / Otro Anuncio
☐ Mailed Postcard / Postal Enviada
☐ Event (ex: Senior Fest) / Evento
☐ E.R. Referral / Referencia de Urgencias
☐ Drove by Our Office / Pasé por la Oficina
☐ Phonebook / Directorio Telefónico
☐ Self Referred / Autorreferencia
☐ Other/Otro: _____
☐

Employment Information / Información de Empleo

Employer Name/Nombre del Empleador: _____ **Phone/Teléfono:** _____
Address/Dirección: _____
City/Ciudad: _____ **State/Estado:** _____ **Zip/C.P.:** _____

Employment Status/Estado de Empleo: (Check one)

☐ Full Time/Completo ☐ Part Time/Medio ☐ Unemployed/Desempleado ☐ Retired/Jubilado ☐ Self Employed/Independiente

Insurance Information / Información de Seguro

Please Check One / Marque Una:

☐ Self Pay/Pago Propio (Sin Seguro)
☐ Insured/Asegurado (Con Seguro)

Health History Information

Patient Name/Nombre del Paciente: _____ **DOB/Fecha de Nac.:** __

Your Symptoms / Sus Síntomas: Check **all symptoms** that apply to you - PLEASE read carefully!

What are you here to take care of today? / ¿Qué viene a tratar hoy? _____

General
- ☐ Weight Loss / Gain
- ☐ Chills / Fevers
- ☐ Fatigue / Lack of Energy

Neurological
- ☐ Dizziness
- ☐ Insomnia
- ☐ Seizure
- ☐ Frequent Headache

Respiratory
- ☐ Cough
- ☐ Production of Sputum
- ☐ Chest Pains
- ☐ Wheezing

Skin / Liver
- ☐ Dry Skin
- ☐ Itchy Skin
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Blood Transfusion
- ☐ Cirrhosis

Upper GI
- ☐ Nausea
- ☐ Vomiting
- ☐ Heart burn / Indigestion
- ☐ Excessive Salivation
- ☐ Loss of Appetite
- ☐ Fullness in Stomach
- ☐ Vomiting of Blood
- ☐ Abdominal Cramps
- ☐ Pain after eating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Change of Stool Width/Diameter

Oral
- ☐ Excessive Burping
- ☐ Bad Breath
- ☐ Hoarseness of Voice

Lower GI
- ☐ Rectal Itching / Pain
- ☐ Hemorrhoid
- ☐ Painful Bowel Movement
- ☐ Ribbon-Like Stool
- ☐ Diarrhea After Eating
- ☐ Visible Blood in Stool
- ☐ Incomplete Bowel Movement
- ☐ Mucus / Slime in Stool
- ☐ Dark / Tarry Stool

Abdominal
- ☐ Abdominal Swelling
- ☐ Excessive Gas / Bloating
- ☐ Dryness of Mouth

Cardiovascular
- ☐ Palpitation of Heart
- ☐ Shortness of Breath
- ☐ Heart Murmur
- ☐ Abnormal Heart Rhythm
- ☐ High Blood Pressure / Heart Issues

Mental Health
- ☐ Mental Disorders
- ☐ Depression
- ☐ Anxiety
- ☐ Forgetfulness
- ☐ Unusual Early Morning Awakening

Urinary / Other
- ☐ Painful Urination
- ☐ Incomplete Urination
- ☐ Frequent Urination
- ☐ Problems with Kidney
- ☐ Diabetes / Blood Sugar Issues
- ☐ Low Thyroid
- ☐ Muscle Pain
- ☐ Stiffness of Joints

Very Important: Please answer Yes/No - Sí/No

☐ Yes ☐ No **1.** Have you ever had blood pressure / heart issues?

☐ Yes ☐ No **2.** To the best of your knowledge, do you have any allergies to anything?

☐ Yes ☐ No **3.** Have you ever had any operations during your life? Please explain below:

_____

_____

☐ Yes ☐ No **4.** Please check if you take any medications, injections, or pills for the following:

☐ Heart / Corazón ☐ Kidney / Riñón ☐ Lungs / Pulmones ☐ Diabetes ☐ Eye / Ojos ☐ Blood Pressure / Presión Arterial

☐ Yes ☐ No **5.** Do you smoke? (If so, how many packs per day? _____)

☐ Yes ☐ No **6.** Do you drink? (If so, how frequently? _____)

Please List Any Allergies you have / Indique sus alergias: _____

_____

Medical Release Form

Patient/Paciente: _____ **DOB/Fecha de Nac.:** _____

SSN #/Seguro Social #: _____

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 / Aviso de Autorización

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 / Registros de atención desde: _____to _____

Records of the following condition(s) / Registros de la(s) condición(es): ____

☐ Other/Otro (especifique): _____

HIV/AIDS / VIH/SIDA: 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.

Patient Signature/Firma del Paciente: _____ **Date/Fecha:** _____

Release To / Entregar A

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

Dr. N. Meah HOUSTON FAX NO. Fax: (979) 292-0488	**Dr. U. Siddiqui** Fax: (979) 292-0488	**YuEun Hwang, AGNP** Fax: (979) 292-0488	**Hazel Aguda, FNP** Fax: (979) 292-0488	**Shantele Johnson, NP** Fax: (979) 292-0488

Family/Spouse / Familia/Cónyuge: _____

Other/Otro (si aplica): _____

Reasons or purpose of this release / Motivo de esta autorización: _____

_____

Patient Signature/Firma del Paciente: _____ **Date/Fecha:** _____

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.

Medical Information

Patient Name/Nombre del Paciente: _____ **DOB/Fecha de Nac.:**

_____ Today's Date/Fecha de Hoy: _____

Pharmacy Name/Nombre de la Farmacia: _____ **Pharmacy Location/Ubicación de la Farmacia: ____**

List of Current Medications & Dosages / Lista de Medicamentos y Dosis

	Medication Name / Nombre del Medicamento	Dosage / Dosis
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Acknowledgement of Privacy Practice Notice

Patient Name/Nombre del Paciente: _____ **Date/Fecha:** _____

Please Read and Check All Items / Lea y Marque Todos los Puntos

I have filled out the information package.

☐ I have received and reviewed my Patient 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 Practitioners 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/Firma del Paciente: _____ **Date/Fecha:** _____

Name of Legal Representative/Nombre del Representante Legal: _____

Relationship/Parentesco: _____

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 must leave a message, you will need to contact the office 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 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 / Nombre del Paciente	Date / Fecha