

# Patient Registration Form

## PATIENT INFORMATION

*Please Print*

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ M.I. \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  M  F

Married  Single  Widowed  Divorced  Separated  Partnered

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Spouse/Nearest-Relative Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship of Emergency Contact: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

EMPLOYMENT:  Full Time Student

Full Time  Part Time  Retired School: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ State: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

GUARANTOR if other than self: Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ M.I. \_\_\_\_\_

**Please show insurance cards at each visit**

INSURANCE-PRIMARY: \_\_\_\_\_

Primary Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Parent  Other \_\_\_\_\_

Employer: \_\_\_\_\_ SS#: \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

INSURANCE-SECONDARY: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Parent  Other \_\_\_\_\_

Employer: \_\_\_\_\_ SS#: \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

If MEDICARE is your SECONDARY insurer, is it secondary due to:  Working Aged  ESRD

Disability  Other (please specify): \_\_\_\_\_

- Are you receiving Black Lung (BL) benefits and the services being performed are covered by BL? \_\_\_\_\_
- Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility? \_\_\_\_\_
- Are services to be paid by a government, such as a research grant? \_\_\_\_\_
- Was the illness/injury due to a work related accident/condition that is covered by WC? \_\_\_\_\_  
Date of injury/illness: \_\_\_\_\_
- Was illness/injury due to a nonwork related accident? \_\_\_\_\_  
Date of accident: \_\_\_\_\_
- What type of accident caused the illness/injury? \_\_\_\_\_
- Was another party responsible for this accident? \_\_\_\_\_
- Are you entitled to Medicare based on Age, Disability or ESRD? \_\_\_\_\_
- Is your spouse currently employed? \_\_\_\_\_
- Do you have GHP coverage based on your own or spouse's employment? \_\_\_\_\_
- Does the employer that sponsors your GHP employ 20 or more employees? \_\_\_\_\_

May we leave a personal message on your answering machine regarding any or all-ongoing medical conditions?

Y  N

May we call you at work?  Y  N      May we call your cell phone?  Y  N

May we contact you by Email?  Y  N IF YES – email address: \_\_\_\_\_

**I hereby authorize Dr. Guerriero/ Dr. Ho to furnish information to insurance carriers concerning my illness and treatment. I understand that sensitive material from my medical history could be included.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**I hereby assign to Dr. Guerriero/ Dr. Ho all payments for medical services rendered to my dependents or myself. I understand I have financial responsibility for any amount not covered by insurance.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

# Medical Questionnaire

UPDATE EVERY SIX (6) MONTHS

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Signature: \_\_\_\_\_

Are you currently enrolled in a **Nursing Home**? \_\_\_\_\_

**Medical History:** (Check all that apply and list any others)

- |  |  |
|--|--|
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> High blood pressure     |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Coronary Artery Disease |
| <input type="checkbox"/> Emphysema     | <input type="checkbox"/> Kidney Stones           |
| <input type="checkbox"/> Cancer        | <input type="checkbox"/> High Cholesterol        |
| <input type="checkbox"/> Stroke        | <input type="checkbox"/> Thyroid Disorder        |
| <input type="checkbox"/> Heart Attack  | <input type="checkbox"/> Other _____             |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Injuries _____          |

**Current Medications:** (List all prescription drugs hormones, and over the counter products you are taking. Include dosage and frequency) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies:** (List any drugs or other substances that have Caused you to have an allergic reaction) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Hospitalization/Surgery History:** (List type of surgery/procedure and approximate date) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Do you use Alcohol?**  No  Yes  
If Yes, how often? \_\_\_\_\_

**Do you smoke?**  No  Yes  Quit  
If Yes, how much? \_\_\_\_\_  
If Quit, when? \_\_\_\_\_

Have any of your **FAMILY** members had any of the following? Relationship: \_\_\_\_\_

- |   |                                   |  |
|---|-----------------------------------|--|
| <input type="checkbox"/> Cancer                                       | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Heart Disease (heart attack, stroke, bypass) |                                   |  |
| <input type="checkbox"/> Kidney problems                              |                                   |  |

**Please check any conditions that you currently or have had:**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Fever               | <input type="checkbox"/> Asthma                                 | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> AIDS or HIV          |
| <input type="checkbox"/> Weight loss         | <input type="checkbox"/> Chest pain                             | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Urinary stones       |
| <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Hypertension                           | <input type="checkbox"/> Seizure         | <input type="checkbox"/> Kidney problems      |
| <input type="checkbox"/> Weakness            | <input type="checkbox"/> Heart rhythm problems                  | <input type="checkbox"/> Headache        | <input type="checkbox"/> Urinary infection    |
| <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Back pain                              | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Bladder problems     |
| <input type="checkbox"/> Constipation        | <input type="checkbox"/> Arthritis                              | <input type="checkbox"/> Depression      | <input type="checkbox"/> Voiding difficulties |
| <input type="checkbox"/> Nausea              | <input type="checkbox"/> Muscle weakness, cramping              | <input type="checkbox"/> Memory loss     | <input type="checkbox"/> Incontinence         |
| <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Skin rashes                            | <input type="checkbox"/> Confusion       | <input type="checkbox"/> Prostate problems    |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Change in size/color of lesions, moles | <input type="checkbox"/> Sore throat     | <input type="checkbox"/> Sexual difficulties  |
| <input type="checkbox"/> Cough               | <input type="checkbox"/> Diabetes                               | <input type="checkbox"/> Sinus problems  | <input type="checkbox"/> Fertility problems   |
| <input type="checkbox"/> Wheezing            | <input type="checkbox"/> Increased thirst or appetite           | <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Testicular problems  |

**Please explain any checked items from above:** \_\_\_\_\_  
\_\_\_\_\_

**Please describe the reason for your visit (describe your medical problem(s) in detail):** \_\_\_\_\_  
\_\_\_\_\_

**If it has been less than six months since this Questionnaire was completed please review info and sign below:**

I have reviewed the above information and there are:  NO changes.  Yes, CHANGES to above information.

Please indicate changes here: \_\_\_\_\_

\_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for taking the time to complete this form. This information is needed to assure the best possible care and will be held in the strictest of confidence.

**William G. Guerriero, M.D.**

**David S. Ho, M.D.**

**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.

\_\_\_\_\_  
*Signature of Patient or Personal Representative*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority

**Physician Financial Interest Disclosure**

Dr. David S. Ho has financial relationships, ownership, or investment interests in **University General Hospital, SightLine Medical Center, and Bostwick Laboratories.**

**Release of Medical Information**

As stated in our *Notice of Privacy Practices*, you may authorize us to release some of your health information to others. This could include persons such as your spouse or your child. If you would like us to be able to disclose information, please check below and you will be given the Authorization form to complete. ***Note: If you do NOT complete a release form, we CAN NOT discuss your health information with anyone other than those referenced in our Notice of Privacy Practices.***

\_\_\_\_\_ I would like to complete an *Authorization Form for Release of Protected Health Information.*

**Financial Responsibility**

I do hereby acknowledge that I am the guarantor of this account and agree to pay for services rendered, including any supplies or pharmaceuticals that are provided to patient for treatment. If any charges are submitted to my insurance carrier by either Dr. Guerriero, Dr. Ho, or by a provider of healthcare services/products/equipment which are ordered by named physicians for the care of the named patient and these services are not covered medical services, I agree to pay for any balance deemed applicable according to my health insurance rules and regulations. If I am not covered by any insurance carrier, I agree to pay for services rendered at the time of service unless other payment arrangements have been made. I am aware that I may request to review and/or receive a copy of this practices' *Billing Policy*.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed Name*

My signature below acknowledges that I do NOT wish to receive a copy of this document at this time.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

**Dr. William G. Guerriero**

**Dr. David S. Ho**

**AUTHORIZATION TO USE OR DISCLOSE  
PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of request: \_\_\_\_\_

**As required by the Privacy Regulations, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.**

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient Health information to be disclosed:

- Complete Health Records     Clinical/Progress note     X-Rays film & report     Laboratory results
- Pathology report     Operative notes     Other (specify) \_\_\_\_\_

For the specific purpose of (describe in detail):

- Continuity of Care     Understanding of my condition     Other (specify) \_\_\_\_\_

**Effective dates** for this authorization: \_\_\_\_/\_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_.

This authorization will expire at the end of the above period.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

**I understand I have the right to:**

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization\*.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

\_\_\_\_\_  
*Signature of Patient or Patient's Authorized Representative*

\_\_\_\_\_  
*Date*

\*My signature below acknowledges that I do NOT wish to receive a copy of this document at this time.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*



**DAVID S. HO, M.D., P.A.**  
**6560 FANNIN, SUITE 1554**  
**HOUSTON, TEXAS 77030**  
**TEL: 281-876-1500**  
**FAX: 713-796-1838**

**NAME:** \_\_\_\_\_

**ADDR:** \_\_\_\_\_

\_\_\_\_\_, TX \_\_\_\_\_

**DATE:** \_\_\_\_\_

**CELL** \_\_\_\_\_

**TELEPHONE: OFFICE** \_\_\_\_\_ **HOME** \_\_\_\_\_

**THE RESULTS OF THE TEST(S) PERFORMED DURING YOUR LAST VISIT ARE AS FOLLOWS:**

**DATE**

**TEST**

**RESULTS**

---

---

---

---

**DAVID S. HO, M.D., P.A.**