

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 # _____

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

Do we have permission to talk to another person (spouse, family member) about your medical condition or finances? Y N

IF YES, name of person: _____ Relationship to you: _____

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:** _____

Internal Use Only

Review date/by: 2009 _____ 2010 _____ 2011 _____ 2012 _____ 2013 _____

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.