

Name _____ SS# _____
 Street Address _____ Date of birth _____ Marital status: S M W Sep D
 City _____ State _____ Zip _____
 Telephone: Home _____ Office _____
 Referred by _____
 Spouse's name _____
 Spouse's employer / address _____
 Emergency contact _____ Tel# _____ Relationship _____

PATIENT EMPLOYER INFORMATION

Employer name _____ Tel# _____
 Employer street address _____ City / State _____ Zip _____
 Patients occupation _____

INSURED PERSON (IF NOT PATIENT)

Name _____ Tel# _____
 Street Address _____ City / State _____ Zip _____
 Relationship to patient _____

INSURANCE

Medicaid # (if applicable) _____ Medicare # (if applicable) _____
 Primary Insurance Company Name _____
 ID # _____ Group # _____ Tel.# _____
 Secondary Insurance Company Name _____
 ID # _____ Group # _____ Tel.# _____

MEDICAL INFORMATION RELEASE AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date _____ Signature _____

I hereby authorize Dr. _____ to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to Dr. _____ (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date _____ Signature _____
 (Patient, parent, or guardian)



Name _____ SS# _____

GENERAL MEDICAL INFORMATION

Describe the current medical problem/reason for today's visit: _____

Present medications: _____

Allergies to medications: _____

Allergies (e.g., itchiness or hives) to specific brands of soap/laundry detergent: _____

Other physicians currently treating you: _____

Previous or other medical problems: _____

List any previous surgeries or hospitalizations (include number of miscarriages and live births): _____

Females only: Are you pregnant, planning a pregnancy or nursing a child? ☐ Yes ☐ NoDo you smoke? ☐ No ☐ Yes ☐ Cigarettes ☐ Pipe ☐ Cigars No. of years _____ How much? _____Interested in stopping? ☐ Yes ☐ NoDo you regularly drink alcohol? ☐ Yes ☐ No How many ounces/beers per day? _____Do you regularly drink coffee? ☐ Yes ☐ No How many cups per day? _____Are you under a lot of pressure at work? ☐ Yes ☐ No Please describe: _____**PERSONAL MEDICAL HISTORY**

Have you ever had any of the following (check all that apply):

☐ Chest pain/pressure/tightening ☐ Asthma ☐ Kidney disease☐ Hypertension ☐ Dizzy spells ☐ Shortness of breath☐ Heart attack ☐ Cancer ☐ TB/Lung disorder☐ Stroke ☐ Diabetes ☐ Ulcers☐ Headaches ☐ Arthritis ☐ Skin disorders☐ Glaucoma ☐ Difficulty hearing ☐ Hepatitis☐ Allergies or Eczema ☐ Glaucoma ☐ Cataracts☐ Depression ☐ Memory loss ☐ Digestive problems☐ Blood in stool ☐ Hemorrhoids ☐ Frequent urinary infections☐ Other: _____**IMMUNIZATIONS**

(Year last received, if known)

Smallpox _____

Tetanus _____

Typhoid _____

Polio _____

Influenza _____

Pneumonia _____

Rubella _____

Hepatitis _____

FAMILY HISTORY

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ECZEMA / PSORIASIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART ATTACK / STROKE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HAY FEVER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Victor Mendiola, M.D.
Family Practice

Communication with family and others involved in your care Form

PATIENT IDENTIFICATION
Name: _____
Date of Birth _____
S.S.# _____
Medical record # _____

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

NAME:	RELATIONSHIP TO PATIENT:	TYPE OF INFORMATION			
		ALL	Scheduling/ Appointment	Medical	Billing/ Insurance
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specific Instructions or Limitations: _____

Validation Code: _____ Please provide this code to any individual who may be involved in coordinating your care or payment for care. They will be asked for this code before information will be released over the phone.

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify your physician's office if you wish to alter the designations above.

Signature of Patient/
Legal Representative: _____ Date: _____

Relationship to Patient: _____

To revoke this authorization, please send a written request with a copy of this form to the address below:

Victor Mendiola, M.D. 7333 North Freeway, ste 250, Houston, Texas 77076

**VICTOR MENDIOLA M.D.
FAMILY PRACTICE OFFICE
7333 NORTH FREEWAY
SUITE 250
HOUSTON, TEXAS 77076**

***USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
FOR TREATMENT, PAYMENT, OR HEALTH OPERATIONS.***

Patient Name _____

I consent to the use or disclosure of my individually identifiable health information as described below.

- ❖ I understand that my individually identifiable health information may be used and disclosed to carry out treatment, payment, or health care operations.
- ❖ I understand that the Notice of Privacy Policies provides a more complete description of the types of uses and disclosures and that I have the right to review the notice before signing this consent.
- ❖ I understand that the terms of the notice may change.
- ❖ I understand that I may request that the covered entity restrict how may individually identifiable health information is used or disclosed to carry out treatment, payment, or health care operations. The covered entity is not required to agree to requested restrictions, but if the covered entity agrees to a requested restriction, the restriction is binding on the covered entity.
- ❖ I understand that I may revoke the consent at any time by notifying the covered entity in writing, except to the extent the covered entity has taken action in the reliance on the consent.

Signature of patient
Or patient's representative _____ Date _____

Printed name of Patient
Or patient's representative _____ Date _____

Relationship to patient _____