HOUSTONIAN MEDICAL ASSOCIATES
PATIENT INFORMATION
THIS FORM MUST BE COMPLETED ANNUALLY

Date: _______________

Name: ____
(last) (first) (middle initial)

Home Address:____
(street address) (city) (state) (zip)

Phone: Home: ______________________ Business: ______________________ Cell: ______________________

Sex (check one): Male Female Social Security No.: _________________ Date of Birth: ________ Age: ____

E-mail Address: Personal ___________________________________Work___________________________________

Insurance Carrier_________________________________ID#____________________________Group#___________

Employer: ____ __Occupation: _______________________________

Employer Address: ____
(street address) (city) (state) (zip)

Marital Status (check one): ___Single ___Married ___Divorced ___Separated ___Widowed

If Applicable: Spouses Name: ____________________________________ Spouse's DOB: _____________________

Spouse's Employer: ____________________________________Spouse's Employer Phone: _____________________

Emergency Contact: ______________________________Relationship: _____________ Phone: ___________________

I, ____ consent/decline to the following:
Patient Name

Initial=Accept Blank=Decline	EMAIL(Initial)	CELL VOICE MAIL(Initial)	HOME VOICE MAIL(Initial)
Appointment Reminders*			
Test Results*			
Insurance/Payment Information*			
Scheduling Information*			
General Information*			

*Any section left blank will not receive message(s)

I, ____, have read and understand the following:
Patient Name

______If you take a medication for maintenance purposes (cholesterol, blood pressure,
Initial diabetes, thyroid, sleep) you are required to have an office visit and in some cases lab work, every six (6) months to continue receiving refills. Please plan accordingly particularly if you utilize mail order prescription service.

______Requests for prescription refills will be accepted via pharmacy only. Patients are
Initial to contact their pharmacy, local and/or mail order for refill requests. Refill requests made by patients directly to Houstonian Medical Associates will not be processed.

______Controlled substance refill requests (handwritten prescription) require a forty-
Initial eight (48) hour notice for processing.

______No antibiotic prescriptions will be authorized without an office visit.
Initial

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 Date