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: _____

CONSENT FOR STRESS TESTING (if applicable)

I understand that to adequately evaluate my cardiovascular system, I will be walking on a treadmill with my pulse, electrocardiogram and blood pressure being monitored by a trained stress technician. The physician will also be nearby. Prior to this exercise, the physician will examine me, my blood pressure and my resting electrocardiogram. The stress test will terminate when I become fatigued or when terminated by the physician.

A small number of patients develop an irregular heart rate with exercise, usually of a minor nature. Some patients develop abnormal blood pressure with exercise. Though rare, it has been reported that a heart attack has occurred with this exercise. Patients can lose their balance on the treadmill, but a handrail is provided. By proper screening by a physician, the chance of my having difficulty is reduced. Emergency equipment and oxygen are readily available.

I understand this signed form releases Houstonian Medical Associates and its staff from any claim by the undersigned arising from, or incident to, this test:

Signed: _____ Date: _____

Name_____

DIET

Yes No

- ☐ ☐ Has your weight changed in the last year? Increase? _____ Decrease? _____
- What do you consider a good weight for yourself?_____
- ☐ ☐ Has your diet changed in the recent months? If yes, how? _____
- ☐ ☐ Do you drink milk? If so, what kind? _____ How many glasses per week? _____
- ☐ ☐ Do you eat cheese? If so, what kind? _____ How many servings per week? _____
- ☐ ☐ Do you use butter/margarine/oils?
- ☐ ☐ Do you eat beef/veal? If so, how many servings per week? _____
- ☐ ☐ Do you eat pork? If so, how many servings per week? _____
- ☐ ☐ Do you eat fish? If so, how many servings per week? _____
- ☐ ☐ Do you eat shellfish? If so, how many servings per week? _____
- ☐ ☐ Do you eat chicken or turkey? If so, how many servings per week? _____
- ☐ ☐ Do you eat fruit? If so, how many servings per week? _____
- ☐ ☐ Do you eat vegetables? If so, how many servings per week? _____
- ☐ ☐ Do you emphasize fiber in your diet? If yes, how so? _____
- ☐ ☐ Do you salt your foods?
- ☐ ☐ Do you drink coffee/tea? If so, how many cups? _____ Caffeinated? ___Decaffeinated? _____
- ☐ ☐ Do you drink alcohol? How many servings per week? _____
- ☐ ☐ Do you eat breakfast?
- How many meals per day do you average? _____

Please describe a typical day of your diet below:

Breakfast	Lunch	Dinner
Other	Other	Other

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, 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.
Initial

_____ Requests for prescription refills will be accepted via pharmacy only. Patients are 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.
Initial

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

_____ 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