17191 St. Lukes Way, Suite 201
The Woodlands, TX 77384
phone: 936-273-2016
fax: 936-273-2018

Patient Information

Name (First) ____________ MI: ________ Last ____________

Date of Birth ____________ Sex ______

Social Security ____________ Driver's License # ____________

Email ____________

Physical Address ____________ Mailing Address ____________

____________ ____________

____________ ____________

Home # ____________ Cell # ____________ Work # ____________

Employer Address ____________

____

Emergency Contact: Name ____________ Relationship: ____________

Phone #: ____________

Spouse's Name: ____________ Date of Birth: ________ SS#: ____________

Employer: ____________ Phone #: ____________

Marital Status: Married: ____ Single ____ Divorced: ____ Widowed: ____

Race: ____________ Ethnicity ____________ Language: ____________

Insurance Information:

Primary Insurance name: ____________ Policy ID ____________

Group # ____________ Policy holder: ____________

Secondary insurance name: ____________ Policy ID ____________

Group # ____________ Policy Holder ____________

Employer: ____________

Whom may we thank for referring you? ____________

WOODLANDS INTERNISTS

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Please list the names of the person and/or persons to whom we can discuss medical information with:

______________________ ______________________

______________________ ______________________

______________________ ______________________

Do you consent to a medical exam and any procedures or test deemed necessary by our providers while you are in our office? YES________ NO________

Do you consent to Woodlands Internists to leave appointment information on voice mail? YES_____ NO_____

Please list the phone # which you would like to use to leave appointment information on________________

Do you consent to Woodlands Internists to leave test result information on voicemail? YES_____ NO______

Please list the phone # which you would like to use for leaving test results__________________________

Do you consent for our office to release medical information to any specialist that we refer you to or that you are currently being treated by? YES_________ NO________

Please list all specialists that you are currently being treated by:

PHYSICIAN__________________________ SPECIALTY_____________________ PHONE #________________

PHYSICIAN__________________________ SPECIALTY_____________________ PHONE #________________

PHYSICIAN__________________________ SPECIALTY_____________________ PHONE #________________

PHYSICIAN__________________________ SPECIALTY_____________________ PHONE #________________

Please list the Pharmacy that you wish to keep on file for your prescriptions:

Local Pharmacy name________________________ Phone #_____________________

Mail order Pharmacy name_____________________ Phone #______________

Member ID #___________________________

______________________________ ______________________________

Patient Signature Date

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FINANCIAL POLICY

Thank you for choosing Woodlands Internists, PA as your health care provider. We are committed to taking care of every aspect of your health. Your clear understanding of our financial policy is important to our professional relationship. We ask that you carefully read & sign the following financial agreement.

**We require a copy of all insurance cards & ask that you present them at each visit along with your driver's license.

Payment IN FULL is required at the time of service for any care; optional payment plan will be designed for SELF PAY patients only and MUST have prior approval before being seen.

______INSURANCE. The patient is responsible for knowing their insurance benefits & if you have a deductible or copayment. If you have an HMO policy you must change your PCP to one of our providers. We will gladly file your insurance claim on your behalf. We will not become involved in disputes between you & your insurance regarding coverage and/or policy benefits. Payment is due at time of service. We accept cash, check, visa, MasterCard & discover. Any balances on your account are due prior to being seen.

______RETURNED CHECKS $35.00 Service fee will be assessed on all dishonored checks. If payment is not received with full amount of check plus service fee within 10 days your information will be filed with The Montgomery County Hot Check Division. If you have 2 occurrences we will no longer be able to accept checks from you.

______APPOINTMENTS when a patient arrives late it is impossible to stay on schedule. If you arrive more than 15 minutes late you may be asked to reschedule and a fee of $25.00 will be charged to your account unless we have been notified 24 hrs in advance. For Diagnostic testing a fee of $50.00 will be added to your account unless we have been notified 24 hrs in advance.

_____ PRESCRIPTIONS It is the patient's responsibility to call the Pharmacy 5 days prior to running out of medication. Refills may take 3-4 days to be refilled. Please do not leave multiple messages, for this may slow down the process. If your insurance does not cover a medication and we need to dispute there will be a charge of $25.00 for us to fill out forms and provide additional information.

_____TRIPLICATES Patients who receive triplicate medication for controlled substances must be seen every 90 days unless the provider has approved in order to receive their monthly prescription. Each prescription must be picked up by the patient and a $5.00 fee will be collected or have a signed release on file. Proof of ID is required. If a prescription is lost or not filled within allowed time frame and we have to re issue a new prescription a $10.00 fee will be charged.

_____CONTROLLED MEDICATIONS All patients that receive chronic pain medications must be seen every month by our providers unless prior approval has been documented. Each patient is required to sign an agreement that they will not receive medications from another doctor or facility. Medications will only be done during office hours and not through our answering service.

_____MEDICAL RECORDS/FORMS There is a $25.00 fee for the first 20 pages of any medical record or form that requires completion and must be paid prior to release.

_____REFERRALS at least a 48 hr advance notice is required for any referral request.

____MEDICATION LIST is required at each visit.

I understand & agree that health insurance coverage is an agreement between an insurance carrier & me. I understand that this office will prepare any necessary reports & forms to assist me in making collections from the insurance company & that any amounts authorized be paid directly to this office. However, I clearly understand & agree that all services rendered to me are charged directly to me & that I am personally responsible for payments. I authorize Woodlands Internists, PA to furnish information to insurance carriers concerning my illness & treatments. In the event that the patient is a minor, I am the parent and/or guardian of said patient & agree that I am responsible for all services rendered to the patient herein.

______________________________ ______________________

Patient/ Guardian Signature DATE

PAST MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY):

__ ANEMIA
__ ARTHRITIS
__ASTHMA/BRONCHITIS
__BLEEDING/BRUISING
__BLOOD DISORDER
__ CANCER (TYPE__________)
__DEPRESSION
__ DIABETES
__DRUG/ALCOHOL DEPENDENCY
__EPILEPSY/SEIZURES
__GOUT
__HEART PROBLEMS
__HEPATITIS
__HIGH BLOOD PRESSURE
__HIGH CHOLESTEROL
__IMMUNE DISORDER
__INTESTINAL DISORDER
__ KIDNEY DISEASE
__ LIVER DISEASE
__LUNG DISEASE
__MIGRAIN HEADACHES
__MULTIPLE SCLEROSIS
__PACEMAKER
__PROSTATE PROBLEMS
__SINUS PROBLEMS
__ SKIN DISORDER
__STROKE
__ THYROID DISEASE
__ULCERS
__VAGINAL INFECTIONS

HAVE YOU EVER BEEN HOSPITALIZED ? __YES __NO IF YES PLEASE LIST REASON

____
____
____

HAVE YOU EVER HAD ANY SURGERIES? __YES __NO IF YES PLEASE LIST WITH DATE

____
____
____
____

______________________________ALLERGIC TO MEDICATIONS?

FAMILY HISTORY

PROBLEM	FAMILY RELATIONSHIP
ALCOHOLISM	
ALZHEIMERS/ DEMENTIA	
CANCER	
DEPRESSION	
DIABETES	
HEART DISEASE	
LIVER DISEASE	
HIGH BLOODPRESSURE	
HIGH CHOLESTEROL	
KIDNEY DISEASE	
OSTEOPEROSIS	
SEIZURES	
STROKE	
THYROID DISEASE	
OTHER	

My Medication List

This list could save MY Life!!!

Name__________ Physician__________ Phone__________
Address__________ Physician__________ Phone__________
City______ State____ Zip____ Birthday______ Physician__________ Phone__________
Emergency Contact__________ Pharmacy__________ Phone__________
Relationship__________ Phone__________ Pharmacy__________ Phone__________
Medical History__________
Drug Alergies__________

Medication	Strength	How Often	Comments		Medicaitons	Strenght	How Often	Comments

*REMEMBER TO UPDATE YOUR MEDICATIONS-Mark out medications that are discontinued. Add new medications started.

Know Your Medications-It Could Save Your Life

In the interest of providing you and/or your family with the best care, Woodlands Internist urges you to carry a complete, up-to-date list of your home medications with you at all times. Medication errors are a primary cause of complications in healthcare. Emergences can occur and this information is critical for the healthcare provider to avoid adverse reactions related to medications that man be new for your treatment at our hospital.

By using a current medication list and keeping it updated, you:

1. Reduce Confusion and save time. It helps you remember your medications.
2. Improves communication. Provide health care provider with a current list of ALL of your medications. The list lets you and/or family member know exactly what medications are to be taken and when.
3. Improve MEDICATION SAFETY. Medications interactions and duplications can be detected and corrected.

In addition to prescribed medications, it is also important to include such things as:

- Eye drops
- Inhalers/Nebulizers
- Creams/Ointments
- Oxygen
- Contraceptives
- Patches that contain medications
- Over the counter medication; examples include Aspirin, Antacids, Vitamins, Laxatives, ECT
- Dietary and herbal supplements, examples include Gingko Biloba, St John's Wart, Green Tea, ECT. (NOTE: when taking herbal supplements, please notify your physician.)

We recommend your designated emergency contact person keep a current list of your home medications. This will help your health care provider to better care for you in the event of an emergency.