



TURNQUEST

SURGICAL SOLUTIONS

17070 RED OAK DRIVE [SUITE 101] HOUSTON, TX 77090 | 18220 SHW 249 [SUITE 360] HOUSTON, TX 77070 | PHONE: 281-444-8090 | FAX: 281-444-8195

NEW PATIENT FORMS

Patient Information			
Name			DOB / /
Insurance	[Primary]	[Secondary]	
Social Security Number			
Home Address			
Phone	[Home]	[Cell]	
Email			

Emergency Contact			
Name		Relationship	Phone

Consent to Leave Messages	Please sign below to give Turnquest Surgical Solutions permission to leave messages on your voicemail.		
Patient Signature		Date	/ /

How Would You Like Us to Remind You of Future Appointments?		
<input type="checkbox"/> Phone Call / Voicemail	<input type="checkbox"/> Email	<input type="checkbox"/> Both

Demographic Information			
Race	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American
	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Other Race
Ethnicity	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Refuse to Report
Language			

Consent to Release Personal Health Information (PHI)	
I understand that information regarding my PHI and/or account information (such as insurance benefits, account balances, medical records, ect.) will not be released to anyone other than myself unless specifically listed below.	
The following individuals may receive information on my behalf:	
Name of Person(s) to Receive Information	Relationship to Patient
1.	
2.	
3.	
Patient Signature	Date / /



PATIENT MEDICAL HISTORY

Name		DOB	/	/	Height	
PCP					Weight	
Reason For Visit						

Please List All Medications You are <u>Currently</u> Taking			
If you are unable to fit all of your medications in the space provided please write on the back of this sheet			
Name of Medication	Dosage	Name of Medication	Dosage

Medications You Are Allergic To:	
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What Pharmacy Do You Use?	
Address	Phone #

Please Check if You Have or Have Had Any of these Medical Conditions				
Diabetes (1 or 2) <input type="checkbox"/>	Heart Disease <input type="checkbox"/>	Asthma <input type="checkbox"/>	GERD <input type="checkbox"/>	Cancer <input type="checkbox"/>
Hypertension <input type="checkbox"/>	High Cholesterol <input type="checkbox"/>	Chest Pain <input type="checkbox"/>	Ulcers <input type="checkbox"/>	Type _____
Sleep Apnea <input type="checkbox"/>	Hepatitis <input type="checkbox"/>	Back Pain <input type="checkbox"/>	Nausea <input type="checkbox"/>	Other:
Thyroid <input type="checkbox"/>	Insomnia <input type="checkbox"/>	Knee/Leg Pain <input type="checkbox"/>	Vomiting <input type="checkbox"/>	
Osteoporosis <input type="checkbox"/>	Neuropathy <input type="checkbox"/>	Abdominal Pain <input type="checkbox"/>	Seizures <input type="checkbox"/>	
Arthritis <input type="checkbox"/>	Anemia <input type="checkbox"/>	AIDS/HIV <input type="checkbox"/>	Stroke <input type="checkbox"/>	

Surgeries & Hospitalizations	

Tobacco Use?			Alcohol Use?		
Current <input type="checkbox"/>	Former <input type="checkbox"/>	Never <input type="checkbox"/>	Current <input type="checkbox"/>	Former <input type="checkbox"/>	Never <input type="checkbox"/>
Cigarettes <input type="checkbox"/>	Chew <input type="checkbox"/>	Pipe <input type="checkbox"/>	How Often?		How Many Drinks Per Occasion?
How Many Per Day?			Daily <input type="checkbox"/>		
1 – 9 (Light) <input type="checkbox"/>	10 – 19 (Moderate) <input type="checkbox"/>	20 – 39 (Heavy) <input type="checkbox"/>	1-2 times per week <input type="checkbox"/>	1 to 2 <input type="checkbox"/>	
	40+ (Very Heavy) <input type="checkbox"/>		3-5 times per week <input type="checkbox"/>	3 to 5 <input type="checkbox"/>	
			1-4 times per month <input type="checkbox"/>	6+ <input type="checkbox"/>	

Recreational Drug Use?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Family Medical History	Any Medical Conditions? If Deceased, what was the Cause of Death?		
Mother		Father	
Maternal Grandmother		Paternal Grandmother	
Maternal Grandfather		Paternal Grandfather	
Siblings			
Children			
Other			

Patient Signature		Date	/	/
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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Overview

Our office uses health information about you for treatment, to obtain payment for treatment for administrative purposes, and to evaluate the quality of care you receive. Your health information is contained in a medical record that is the physical property of our practice.

The law requires us to maintain the privacy of your **Protected Health Information (PHI)** in accordance with this Notice of Privacy Policies as long as this notice remains in effect. We are also required to provide you with a copy of this notice which contains our privacy practices, our legal duties, and your rights concerning PHI. We may revise our privacy practices and the terms of our notice at any time as permitted or required by law. We reserve the right to apply a change in our policies to previously received PHI. We will promptly revise and distribute our notice whenever there is a material change to the uses or disclosures, your individual rights, our legal responsibilities, or other privacy practices stated in this notice.

Our Privacy Practice

Use and disclosure. We may use or disclose your PHI for treatment, payment or health care operations. Your PHI may be used to provide you with medical treatment for services; information obtained by a health care provider such as physician nurse or other health care provider. Information will be recorded in your records that are related to your treatment. This information is necessary for health care providers to determine what treatment you should receive.

Sign

I acknowledge that I was offered and/or provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read) and understand the notice.

Patient Printed Name			
Patient Signature		Date	/ /



AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name		Date of Birth	/	/
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I authorize the following individual/organization to disclose the above named individual's health information:

Provider Name				
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Phone Number		Fax Number	
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Please release the following information:

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For the purpose of:

To:	<p>Turnquest Surgical Associates Dr. Dexter G. Turnquest and Dr. Jojy M. George 17070 Red Oak Drive [Suite 101] Houston, TX 77090 18220 SHW 249 [Suite 360] Houston, TX 77090 Phone: 281-444-8090 Fax: 281-444-8195</p>
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I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or HIV. It may also include information about behavioral or mental health services. I understand that the information release is for the specific purpose stated above. I understand that I have the right to revoke this authorization at any time and that if I do I must do so in writing and present my written revocation to the individual or organization releasing information. The revoke will not apply to information already released in response to this authorization. Revocation does not apply to insurance companies when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect copy information that carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Printed Name of Patient		Date	/	/
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Signature of Patient				
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