Oza Family Care and Wellness Center
Vijay Oza, MD
10490 Huffmeister Road Suite D
Houston, TX 77065-5654
Tel: 281-477-4855
Fax: 281-978-2135

PATIENT INFORMATION FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

PATIENT INFORMATION:

NAME: ____
(Prefix) (First) (Middle Initial) (Last) (Suffix)

SEX: Male or Female or unknown DATE OF BIRTH:______________________ (mm/dd/yyyy)

SSN: ______________________(Optional)

MOBILE PHONE:________________ (Must for patient portal) May we leave a message? □Yes □No

HOME PHONE:____________________ May we leave a message? □Yes □No

WORK PHONE:____________________ May we leave a message? □Yes □No

E-mail: ____ May we email you? □Yes □No
Please note: Email address is necessary to sign up for your FREE online **personal health records. Please ask us for details.*

HOME or MAILING ADDRESS:

____
Street Address City State Zip

PREFERRED METHOD OF COMMUNICATION: Mobile Home Work Email (Circle One)

PAYMENT INFOMRATION: Self pay Insurance (Circle One)

INSURANCE DETAILS: (Optional; please provide insurance card with your photo ID)

PAYER: ______________________INSURANCE ID: ___________________ GROUP ID:____________

PAYER CLAIMS ADDRESS:____

PAYER PHONE NUMBER:__________________________________

GUARANTOR INFORMATION:

PATIENT RELATIONSHIP TO GUARANTOR: ___________________________

GUARANTOR NAME:____
First MI Last

ADDRESS: Same as above OR ____
Street Address

____
City State Zip

GUARANTOR DOB:________________(mm/dd/yyyy) SEX: Male or Female or Unknown

PRIMARY PHONE:_____________________SECONDARY PHONE:_____________________

PREFERRED PHARMACY:

Pharmacy Name: _________________________________Phone Number: _________________________

Pharmacy address:____Zip code:________________

DEMOGRAPHICS:

PREFERRED LANGUAGE: English Spanish (Circle One) or _________________________________

ETHNICITY/RACE: Declined American Indian or Alaska Native Hispanic or Latino Asian

African American Native Hawaiian or other pacific Islander White (Circle one)

Other:________________________________

NEXT OF KIN INFORMATION OR EMERGENCY CONTACT INFORMATION:

PATIENT RELATIONSHIP TO NEXT OF KIN: ___________________________

NEXT OF KIN NAME:____
First MI Last

PRIMARY PHONE:_________________________SECONDARY PHONE:_________________________

ADDRESS: Same as above OR ____
Street Address

____
City State Zip

Referred by (if any): ____

MEDICAL HISTORY:

Allergies	Asthma/ COPD	AIDS/HIV	High Blood Pressure
Thyroid Problems	Kidney Trouble	Migraines	Low Blood Sugar
Seizure	Sinus Trouble	Fainting Spells	Diabetes
Sexually Transmitted Disease		Mental Health Problem	Stroke
High Cholesterol	Arthritis	Heart Disease	

Other: ____
____

SOCIAL HISTORY:

SMOKING □ Yes □No If yes; how many cig a day? _________Ex-Smoker: □ Yes, Date____________
ALCOHOL □ Yes □No If yes; how many beer? ______ How many drinks of hard liquor?___________
RECREATIONAL DRUGS □ Yes □No If yes, describe ____________________________________
PHYSICAL ACTIVITY □ Yes □No If yes; how many times/week? ___________________________

FAMILY HEALTH HISTORY:

Heart Attack:____________________________Stroke:____
Diabetes:________________________________ High Blood Pressure:_________________________________
Cancer:__________________________________ Sudden Death:_______________________________________
Other:____

SURGICAL HISTORY:

APPENDIX: _________________ (date) GALL BLADDER:______________(date) _______________
HEART STENT:______________ (date) UTERUS: ______________________(date) ________________
HEART BYPASS:_____________ (date) Other: ________________________ (date) ________________
Other: _________________________ (date) Other: _________________________(date) ________________

PREVENTIVE CARE

Last Physical Examination: _______________ Last Menstrual Period:________________________
Last Colonoscopy: ______________________ Last Mammogram:___________________________
Last Retina Eye exam: ___________________ Last PAP smear: _____________________________
Last Prostate (PSA):_____________________ Last Bone Density (DEXA): _______________
List any abnormal result details here: ____

ALLERGIES:
Allergies to ANY DRUG OR FOOD:____

CURRENT MEDICATIONS:

Name	Dosage	Name	Dosage

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RELEASE OF MEDICAL INFORMATION

____
Patient Name

____
Address

________________ ________________ ______________________
Phone Date of Birth Social Security Number

In accordance with HIPAA regulations, we require written authorization prior to sending any protected health information. If you wish for your medical records to be sent to any family members please list below their names and addresses.
Upon signing this form, you are granting consent for our practice to use and disclose your protected health information for the purposes of payment, treatment and health care operations.
If you request more detailed information about how we may use and disclose this protected health information please consult with our staff. You have a legal right to review our full policy regarding the release of protected health information before you sign this consent, and we encourage you to ask any questions you may have. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of payment, treatment or health care operations, however, we are not required by law to grant your request. If we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Please Initial if you authorize us to speak to any of the following regarding your health information:
_______Spouse _______Mother _______Father _______Daughter ________Son

Please write the names and relationship of any other friends/family you authorize us to speak with:____
____

____ _____________________

Signature (Must sign) Date

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Statement of Patient Financial Responsibility

Patient Name: ____ DOB: ____________________

Oza Family Care & Wellness Center (the "Practice") appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full. Any amounts not paid by you when due shall accrue interest until paid at the lesser of 18% per annum or the maximum rate allowed by applicable law.

I agree to pay any costs incurred by the Practice in collecting any amounts due including, without limitation, collection agency fees and attorney's fees.

I have read the above policy regarding my financial responsibility to the Practice, for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to the Practice, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature____________________________________Date________________________
Guarantor Signature__________________________________ Date _________________________
(If guarantor is not the patient) (Must sign)

Co-Pay Policy
Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature ____________________________Date _________________________
(Must sign)

Consent for Treatment and Authorization to Release Information

I hereby authorize the Practice, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize the Practice, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature ________________________________Date __________________________
(Must sign)

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.

The Practice will notify you in writing, via certified mail, if you are discharged from care.
I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature ______________________________ Date _____________________________
(Must sign)

Self-Pay

I do not have health insurance and will be responsible for services rendered here at the Practice. I agree to pay the Practice, the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature ______________________________ Date _____________________________
(Must sign)

HIPAA information

I have been made aware of HIPAA information and I can review them on www.ozafamilycare.com at anytime.
I have been given a hardcopy of this information upon my request.

Patient/Guarantor Signature ______________________________ Date _____________________________
(Must Sign)