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 Demographics

Name:	DOB: / /
SSN:	Marital Status:
Race/Ethnicity:	Language:
Home Address:	
Phone Number: (Home)	(Cell)
Email Address:	
Primary Care Physician:	Referring Physician:
Phone: Fax:	Phone: Fax:

Insurance Information

Primary Insurance Co.:	Secondary Insurance Co.:
Subscriber:	Subscriber:
DOB: SSN:	DOB: SSN:
Relationship to Patient:	Relationship to Patient:

Pharmacy:	
Address:	**Phone #:**

Consent to Leave Messages	Please sign below if you would like to give our office permission to leave messages on your voicemail.
Patient Signature:	**Date:** / /

Consent to Release Personal Health Information (PHI)

By signing below 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:

Name of Person(s) to Receive Information	Relationship to Patient
1.	
2.	
3.	
Patient Signature:	**Date:** / /

Emergency Contact

Name:	Phone Number:
Relationship to Patient:	

PATIENT MEDICAL HISTORY

Name:	**DOB:** / /	**Height:**
PCP:	**Referring MD:**	**Weight:**
Reason For Visit:		

Please List All Medications You are Currently 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:

Please Check if You Have or Have Had Any of these Medical Conditions

Diabetes (1 or 2) ☐	**Heart Disease** ☐	**Asthma** ☐	**GERD** ☐	**Cancer** ☐
Hypertension ☐	**High Cholesterol** ☐	**Chest Pain** ☐	**Ulcers** ☐	Type _____
Sleep Apnea ☐	**Hepatitis** ☐	**Back Pain** ☐	**Nausea** ☐	**Loud Snoring** ☐
Thyroid ☐	**Insomnia** ☐	**Knee/Leg Pain** ☐	**Vomiting** ☐	**Sleep Disturbance** ☐
Osteoporosis ☐	**Neuropathy** ☐	**Abdominal Pain** ☐	**Seizures** ☐	_____ ☐
Arthritis ☐	**Anemia** ☐	**AIDS/HIV** ☐	**Stroke** ☐	

Surgeries & Hospitalizations	

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

Recreational Drug Use?	Yes ☐	No ☐

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:** / /

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Authorization to Disclose Health Information

I hereby authorize the use or disclosure of information from the medical record of:			
Patient Name		Date of Birth	/ /

I authorize the following individual/organization to disclose the above named individual's health information:			
Provider Name			
Phone Number		Fax Number	
Please release the following information:			
For the purpose of:			
To:	**Turnquest Surgical Solutions** Dexter G. Turnquest, MD, FACS Victoria C. Chang, MD 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		

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:	
Signature of Patient:	**Date:** / /