Houston Gastrointestinal & Liver Clinic, P.A.
Sreelatha Reddy, M.D.

Patient Demographics

Name: (First, M, Last):_____ Social Security # _____

Date of Birth: _____ Sex: MALE / FEMALE Marital Status: S / M / W / D

Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____Cell Phone: _____ Work Phone: _____

Referring Physician: _____

Email: _____ Race: _____ Ethnicity: _____ Language: _____

Emergency Contact Information

Name: Relationship to patient:

Phone number: Work number:

Insurance Information

Primary Insurance	Secondary Insurance
Name: _____	Name: _____
ID # _____	ID # _____
Group # _____	Group # _____
Insured Name: _____	Insured Name: _____
Date of Birth: _____	Date of Birth: _____

I hereby assign, transfer, and set over, Houston Gastrointestinal & Liver Clinic, P.A. all of my rights, title, and interest to my medical reimbursement benefits, under my insurance policy. I authorize the release of any medical information needed to determine these benefits.

This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance policy.

PATIENT'S SIGNATURE: Date:

Houston Gastrointestinal & Liver Clinic, P.A.

Sreelatha Reddy, M.D.

Patient Medical History Form

Patient Name: _____ Date of Birth: _____

Referring Physician: _____Specialty: _____ Phone# _____

Pharmacy Name, number, and address:_____

REASON FOR YOUR OFFICE VISIT: _____

Medication: Please list all Prescription Medications, Over the counter Vitamins, Herbs or Supplements.

Medication/Supplement Name	Dose/Frequency		Medication/Supplement Name	Dose/Frequency

Allergies: Do you have any allergies or adverse reactions to ANY medications?

Medication	Reaction		Medication	Reaction

*Are you allergic or sensitive to the following? □ Latex □ Adhesive Tape □ Iodine/I.V. Contrast

Medical History: Please list any medical problems you have had in the past.

Medical problem	Date of occurance

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Patient Medical History Form

Patient Name: _____ Date of Birth: _____

Surgical History: **NO PRIOR SURGERIES** ☐

Procedure Name	Date		Procedure Name	Date

Hospitalizations: Please list any hospital admissions you have had.

Reason	Date (Month/Year)		Reason	Date (Month/Year)

Social History:

Tobacco Use: □ Never □ Former* □ Current * Quit in month / year ____ / ____

_____ amount / pack / day for _____ years

Alcohol Use: □ Never □ Beer □ Wine □ Other Liquor Drinks/Amount Per Day _____

* Quit in month / year _____ / _____

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Patient Medical History Form

Patient Name: _____ Date of Birth: _____

Family History:

Siblings: _____ Brother(s) _____ Sister(s)

Children: _____ Sons(s) _____ Daughter(s)

Notes

Please check (√) all that apply:

	Diabetes	Hypertension	Heart Disease	Mental Illness	Cancer
Father					
Mother					
Son					
Daughter					
Spouse					
Siblings					
Children					
Paternal Grandfather					
Paternal Grandmother					
Maternal Grandfather					
Maternal Grandmother					
Paternal Uncle					
Paternal Aunt					
Maternal Uncle					
Maternal Aunt					

Houston Gastrointestinal & Liver Clinic, P.A.

Sreelatha Reddy M.D.
3030 S. Gessner Rd., Suite 120, Houston, TX 77063
Phone: 713-773-1800 ▪ Fax: 713-773-1809

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I hereby authorize ***Sreelatha Reddy M.D.*** to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, ***Sreelatha Reddy M.D.*** can refuse to treat me.

I have been informed that ***Sreelatha Reddy M.D.*** has prepared a notice ("Notice"), which more fully describes the uses, and disclosures that can be made of my individually identifiable health information for treatment, payment, and health care operations. I understand that I have the right to review such "Notice" prior to signing this consent.

I understand that I may revoke this consent at any time by notifying ***Sreelatha Reddy M.D.,*** in writing, but if I revoke my consent, such revocation will not affect any actions that ***Sreelatha Reddy M.D.*** took before receiving my revocation.

I understand that ***Sreelatha Reddy M.D.*** has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that ***Sreelatha Reddy M.D.*** restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or health operations. I understand that ***Sreelatha Reddy M.D.*** does not have to agree to such restrictions, but that once restrictions are agreed to; ***Sreelatha Reddy M.D.*** must adhere to such restrictions.

_____ _____

Signature of patient or patient's representative Date

_____

Printed Name of patient or patient's representative

_____

Relationship to patient