



**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

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**PATIENT INFORMATION FORM**

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

Name:

\_\_\_\_\_

(Last)

\_\_\_\_\_

(First)

\_\_\_\_\_

(Middle Initial)

Name of parent/guardian (if under 18 years):

\_\_\_\_\_

(Last)

\_\_\_\_\_

(First)

\_\_\_\_\_

(Middle Initial)

Home Phone: (\_\_\_\_) \_\_\_\_\_

May we leave a message?  Yes  No

Cell/Other 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.*

Address: \_\_\_\_\_

Street Address

City

State

Zip

How long have you been living at this address? \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex:  Male  Female

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Marital Status:

Never Married  Married  Domestic Partnership  Divorced  Widowed

Referred by (if any): \_\_\_\_\_

Emergency Contact Information:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Emergency Phone: \_\_\_\_\_

### Medical History

Have you ever had or suffered from any of the following:

- |                              |                |                       |                     |
|------------------------------|----------------|-----------------------|---------------------|
| 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: \_\_\_\_\_

Do you have any ALLERGIES to:

- |              |  |                           |  |
|--------------|--|---------------------------|--|
| Anesthesia   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sulfa Drugs               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Narcotics    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Penicillin or Antibiotics | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Barbiturates | <input type="checkbox"/> Yes <input type="checkbox"/> No | Iodine                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other        | <input type="checkbox"/> Yes <input type="checkbox"/> No |                           |  |

If you have other allergies please describe: \_\_\_\_\_

Surgeries (Type and Date): \_\_\_\_\_

Current Medications:

Name	Dosage	Name	Dosage

### Family Medical History

*Please list all first-degree relatives who have experienced the following:*

Heart Attack: \_\_\_\_\_

Stroke: \_\_\_\_\_

Diabetes: \_\_\_\_\_

High Blood Pressure: \_\_\_\_\_

Cancer: \_\_\_\_\_

Sudden Death: \_\_\_\_\_

Other: \_\_\_\_\_

### Social History

Do you exercise regularly?  Yes  No

Do you have any sleep related problems ?  Yes  No.

Do you use tobacco?  Yes  No; if yes; how many cig a day/week?

Do you use alcohol?  Yes  No, if yes; how many beer? \_\_\_\_\_ How many drinks of hard liquor? \_\_\_\_\_

Do you use any recreational drugs?  Yes  No, if yes, describe \_\_\_\_\_



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RELEASE OF MEDICAL INFORMATION

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\_\_\_\_\_  
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

\_\_\_\_\_  
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)

**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 \_\_\_\_\_

## 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 \_\_\_\_\_

## 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 \_\_\_\_\_

## 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 \_\_\_\_\_

## HIPAA information

I have been made aware of HIPAA information and I can review them on [www.ozafamilycare.com](http://www.ozafamilycare.com) at anytime.  
I have been given a hardcopy of this information upon my request.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_