Patient Registration Form

PATIENT INFORMATION *Please Print*

Last Name: _____ First: _____ M.I. _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Gender: ☐ M ☐ F

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Partnered

Home Phone: _____

Cell Phone: _____ Social Security #: _____

Spouse/Nearest-Relative Name: _____Phone: _____

Emergency Contact: _____ Phone: _____

Relationship of Emergency Contact: _____

Employer: _____ Work Phone: _____

EMPLOYMENT: ☐ Full Time Student

☐ Full Time ☐ Part Time ☐ Retired School: _____

Driver's License #: _____ State: _____

Pharmacy: _____Phone: _____

GUARANTOR if other than self: Name: _____ SS#: _____

Relationship: _____ Phone: _____

Address: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Last Name: _____ First: _____ M.I. _____

INSURANCE-PRIMARY: _____

Primary Subscriber Name: _____ Date of Birth: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Employer: _____ SS#: _____

ID # _____ Group # _____

INSURANCE-SECONDARY: _____

Subscriber Name: _____ Date of Birth: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Employer: _____ SS#: _____

ID # _____ Group # _____

If MEDICARE is your SECONDARY insurer, is it secondary due to: ☐ Working Aged ☐ ESRD

☐ Disability ☐ Other (please specify): _____

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By signing below I give permission for **David S. Ho, M.D., P.A.** to download pharmacy benefits data electronically through e-Med, to obtain formulary information, and information about other prescriptions prescribed by other providers using e-Med.

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May we leave a personal message on your answering machine regarding any or all-ongoing medical conditions?
☐ Y ☐ N

May we call you at work? ☐ Y ☐ N May we call your cell phone? ☐ Y ☐ N

Do you want to use the patient portal? ☐ Y ☐ N IF YES, email address: _____

I hereby authorize David S. Ho, M.D./Jed-Sian Cheng, M.D., M.P.H. to furnish information to insurance carriers concerning my illness and treatment. I understand that sensitive material from my medical history could be included.

I hereby assign to David S. Ho, M.D./Jed-Sian Cheng, M.D., M.P.H. all payments for medical services rendered to my dependents or myself. I understand I have financial responsibility for any amount not covered by insurance.

Signed: _____ Date: _____

MEDICAL QUESTIONNAIRE UPDATE EVERY SIX (6) MONTHS

Last Name: _____ First Name: _____ Date: _____
Date of Birth: _____ Signature: _____

Are you currently enrolled in a **Skilled Nursing Facility / Nursing Home ?** _____

Medical History: (Check all that apply and list any others)

- ☐ Asthma
- ☐ Diabetes
- ☐ Emphysema
- ☐ Cancer
- ☐ Stroke
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ High blood pressure
- ☐ Coronary Artery Disease
- ☐ Kidney stones
- ☐ High cholesterol
- ☐ Thyroid Disorder
- ☐ Other _____
- ☐ Injuries _____

Current Medications: (List all prescription drugs, hormones, and over the counter products you are taking. Include dosage and frequency) _____
_____
_____
_____
_____

Allergies: (List any drugs or other substances that have Caused you to have an allergic reaction) _____
_____
_____
_____

Hospitalization/Surgery History: (List type of surgery/procedure and approximate date)
_____
_____
_____

Do you use alcohol? ☐ No ☐ Yes
If Yes, how often? _____
Do you smoke? ☐ No ☐ Yes ☐ Quit
If Yes, how much? _____
If Quit, when? _____

Have any of your **FAMILY** members had any of the following? Relationship: _____
☐ Cancer ☐ High Blood Pressure
☐ Diabetes ☐ Kidney problems
☐ Heart disease (heart attack, stroke, bypass)

Were you given the **flu** vaccination? ☐ No ☐ Yes
If yes, when? _____

Were you given the **pneumonia** vaccination? ☐ No ☐ Yes
If yes, when? _____

Please check any conditions that you currently or have had:

- ☐ Weakness
- ☐ Chills
- ☐ Weight Loss
- ☐ Fever
- ☐ Vision Loss
- ☐ Ear pain
- ☐ Hearing loss
- ☐ Chest pain
- ☐ Palpitations
- ☐ Constipation
- ☐ Diarrhea
- ☐ Melena
- ☐ Nausea
- ☐ Vomiting
- ☐ Heart rhythm problems
- ☐ Muscle weakness
- ☐ Joint swelling
- ☐ Rash
- ☐ Skin change
- ☐ Numbness
- ☐ Dizziness
- ☐ Headache
- ☐ Depression
- ☐ Insomnia
- ☐ Easy bruising
- ☐ Easy bleeding
- ☐ Night sweats
- ☐ Sneezing
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ Hepatitis
- ☐ AIDS or HIV
- ☐ Urinary stones
- ☐ Kidney stones
- ☐ Urinary infection
- ☐ Bladder problems
- ☐ Voiding difficulties
- ☐ Incontinence
- ☐ Prostate problems
- ☐ Sexual difficulties
- ☐ Fertility problems
- ☐ Testicular problems

Please explain any checked items from above: _____
_____

Please describe the reason for your visit (describe your medical problem(s) in detail): _____
_____

If it has been less than six months since this Questionnaire was completed, please review info and sign below:

I have reviewed the above information and there are: ☐ NO changes. ☐ Yes, CHANGES to above information.
Please indicate changes here: _____
_____ Signature: _____ Date: _____

Thank you for taking the time to complete this form. This information is needed to assure the best possible care and will be held in the strictest of confidence.

Revised 08/18/2016

OFFICE & FINANCIAL POLICIES

David S. Ho, M.D. • Jed-Sian Cheng, M.D., M.P.H.

Physician Financial Interest Disclosure: Dr. David S. Ho has financial relationships, ownership, or investment interests in **SightLine Radiation, Lithotripsy machines, and Aspire Fertility Houston.**

Initial _____ **Ultrasound Usage**: Ultrasound is utilized in this office as means to confirm, diagnose and treatment of medical conditions.

Initial _____ **Physician Assistant**: Our office has on staff a Physician Assistant and a Nurse Practitioner to assist in the delivery of medical care. He/She is a graduate of a certified training program. Under the supervision of a physician, a physician assistant or a nurse practitioner can diagnose, treat and monitor common acute and chronic diseases as well as providing health care.

Initial _____ **Notice of Privacy**: I have reviewed this office's *Notice of Privacy* Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Initial _____ **Insurance**: When making an appointment with one of our physicians, it is your responsibility to confirm with your insurance company that the physician is currently under contract with your plan**.** ***If your plan requires a referral and you or your provider does not provide one by your scheduled appointment time, please be prepared to pay for your visit in full or reschedule***.

Initial _____ **Late arrivals**: If you arrive more than 30 minutes past your scheduled appointment time, you may be rescheduled so that other patients are not inconvenienced.

Initial _____ **Check-In**: your time is very important to you and to us. It is extremely important that you provide each piece of information that is requested on both the Patient Information and Medical History Forms. This will avoid delays in creating your chart and account. Although we verify your benefits before your initial appointment, you must present your current insurance card along with a valid picture I.D. in order to verify your identity. This will insure that all information is entered accurately and will prevent errors in filing your claims. Without the insurance card, we will be unable to file your insurance and you will be responsible for the day's charges. In addition, you will be asked to verify demographic and insurance information every 6 months so that our records remain up-to-date.

Initial _____ **Check-Out**: Please note that payment for all co-pays and/or deductibles is due at the time of service. Typically, only an Office Visit charge is covered by your co-pay and any additional services or treatment are subject to your plan's specific benefits. ***The patient is responsible for knowing their insurance benefit coverage and whether a referral is needed for the specialist visits, and obtaining the referral from your PCP before the scheduled appointment***. It is strongly recommended that you contact your insurance company prior to your visit to get an understanding of your benefits.

Initial _____ **Telemed Consultation After Hours**: If you request an urgent consultation with your provider after normal business hours resulting in a telephone encounter, you may be charged normal office visit for your provider's time and service. This fee will be your responsibility and will be charged to your patient account.

Initial _____ **No Shows and late cancellations**: We require a 24-hour advance notice if you must cancel your appointment. For your convenience, we offer email and appointment reminder calls 48 hours prior to your appointment which will allow you to cancel at that time. If you **no show or cancel** on the same day of your appointment, a **$50 fee** will be assessed to your account. No future appointment will be set up until payment is received.

Initial _____ **Surgery Deposit**: Please carefully consider your surgical date prior to scheduling. Your surgery requires the coordination of numerous individuals, including our staff, your surgeon, the anesthesiology department and the hospital. Rescheduling procedures requires significant time and expense, particularly if the operating room goes unused because of a late cancellation. Please be courteous and promptly make our staff aware of any decision to reschedule or cancel your surgery.

- **You will be asked to pay a deposit of $100 when scheduling your surgery. This deposit is in addition to any fees you may owe for coinsurance or deductibles. Once the surgery is performed, this $100 deposit will be returned.**
- **If you no show, reschedule or cancel your surgery for any reason with less than 72 hour notice, the $100 fee is forfeited.**
- **In order to reschedule your surgery, you must again place a $100 deposit**

Initial _____ **FMLA & Disability Paperwork**: We charge a $25 fee for completing FMLA and Disability paperwork.

_____ _____

Signature *Date*

_____ _____

Patient's Full Name (please print) DOB (date of birth)

David S. Ho. M.D., P.A.

David S. Ho, M.D. Jed-Sian Cheng, M.D., M.P.H.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____
Address: _____
Date of Birth: _____ Date of Request: _____

As required by the Privacy Regulations, this practice may not use or disclose your protected health information <u>except as provided in our Notice of Privacy Practices without your authorization.</u>

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:
Name: _____ Relationship: _____

Patient Health Information to be disclosed:
☐ Complete Health Records ☐ Clinical/Progress note ☐ X-Rays film & report ☐ Laboratory results
☐ Pathology report ☐ Operative note ☐ Other (specify) _____

For the specific purpose of (describe in detail):
☐ Continuity of Care ☐ Understanding of my condition ☐ Other (specify) _____

Effective dates for this authorization: ____/___/_____ through ____/___/_____.
This authorization will expire at the end of this period.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.*
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____

Signature of Patient or Patient's Authorized Representative *Date*

DAVID S. HO, M.D.
JED-SIAN CHENG, M.D., M.P.H
6560 FANNIN ST., SUITE 1554
HOUSTON, TEXAS 77030
TEL: (713) 796-1500
FAX: (713) 796-1838

NAME: _____

ADDR: _____

_____, _____

DATE: _____

CELL: _____

TELEPHONE: OFFICE: _____ HOME: _____

THE RESULTS OF THE TEST(S) PERFORMED DURING YOUR LAST VISIT ARE AS FOLLOWS:

DATE	TEST	RESULTS

DAVID S. HO, M.D. / JED -SIAN CHENG, M.D., M.P..H.