

PATIENT INFORMATION SHEET – PLEASE PRINT CLEARLY

TODAY'S DATE: \_\_\_\_\_ ACCOUNT #: \_\_\_\_\_

FULL LEGAL NAME: \_\_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

ADDRESS: \_\_\_\_\_ CITY / STATE / ZIP: \_\_\_\_\_

PHONE (HOME): \_\_\_\_\_ (WORK): \_\_\_\_\_ (CELL): \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ JOB TITLE/POSITION: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_ CITY / STATE / ZIP: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

NAME OF SPOUSE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

SPOUSE'S EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

NAME OF INSURANCE: \_\_\_\_\_ ID#: \_\_\_\_\_

INSURANCE ADDRESS: \_\_\_\_\_

INSURANCE PHONE #: \_\_\_\_\_ INSURED SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ INSURED DATE OF BIRTH: \_\_\_\_\_

INSURED'S BILLING ADDRESS (IF DIFFERENT): \_\_\_\_\_

MEDICARE/MEDICAID #: \_\_\_\_\_

SECONDARY INSURANCE INFORMATION: \_\_\_\_\_

1. ARE YOU ALLERGIC TO ANY MEDICATIONS? CIRCLE ONE: YES NO

MEDICATION: \_\_\_\_\_ REACTION: \_\_\_\_\_

MEDICATION: \_\_\_\_\_ REACTION: \_\_\_\_\_

MEDICATION: \_\_\_\_\_ REACTION: \_\_\_\_\_

MEDICATION: \_\_\_\_\_ REACTION: \_\_\_\_\_

2. WHY DID YOU COME IN TODAY: \_\_\_\_\_

ARE YOU HERE FOR A WORK-RELATED ACCIDENT?: YES NO

3. DO YOU HAVE AN ADVANCED DIRECTIVE/LIVING WILL?: YES NO

IF NOT, WOULD YOU LIKE TO DISCUSS THIS WITH YOUR DOCTOR TODAY?: YES NO

NAME: \_\_\_\_\_ ACCOUNT #: \_\_\_\_\_

4. PREVIOUS HOSPITALIZATIONS: PLEASE LIST EVERY ADMISSION AND SURGERY YOU HAVE HAD (INCLUDING OUTPATIENT SURGERIES).

DATE: \_\_\_\_\_ REASON: \_\_\_\_\_

DATE: \_\_\_\_\_ REASON: \_\_\_\_\_

DATE: \_\_\_\_\_ REASON: \_\_\_\_\_

DATE: \_\_\_\_\_ REASON: \_\_\_\_\_

DATE: \_\_\_\_\_ REASON: \_\_\_\_\_

5. WHAT ILLNESSES HAVE YOU HAD FOR LONGER THAN A MONTH? (I.E. ASTHMA, DIABETES, HYPERTENSION, ETC.)

DATE DIAGNOSED: \_\_\_\_\_ DIAGNOSIS: \_\_\_\_\_

DATE DIAGNOSED: \_\_\_\_\_ DIAGNOSIS: \_\_\_\_\_

DATE DIAGNOSED: \_\_\_\_\_ DIAGNOSIS: \_\_\_\_\_

6. ARE YOU PREGNANT?: YES NO IF SO, HOW MANY WEEKS?: \_\_\_\_\_

7. PLEASE GIVE DATES OF LAST TEST/INJECTION:

<b>IMMUNIZATIONS</b>	<b>FOR FEMALES</b>	<b>FOR MALES OVER 50</b>
PPD SKIN TEST: _____	MAMMOGRAM: _____	PROSTATE EXAM: _____
TETANUS: _____	PAP SMEAR: _____	PSA LAB TEST: _____
PNEUMONIA: _____	BONE DENSITY: _____	
HEPATITS B: _____		
COLONOSCOPY: _____		
LAST CHOLESTEROL TEST: _____		

8. HAVE YOU EVER BEEN INVOLVED IN A SERIOUS ACCIDENT: YES NO

WHAT TYPE?: \_\_\_\_\_ WHEN?: \_\_\_\_\_

9. WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? PLEASE INCLUDE ALL OVER THE COUNTER MEDICATIONS, ORAL CONTRACEPTIVES, PRESCRIPTIONS BY OTHER PHYSICIANS, AND EYE MEDICATIONS.

MEDICATION: \_\_\_\_\_ DATE: \_\_\_\_\_ DOSE/FREQUENCY: \_\_\_\_\_

MEDICATION: \_\_\_\_\_ DATE: \_\_\_\_\_ DOSE/FREQUENCY: \_\_\_\_\_

MEDICATION: \_\_\_\_\_ DATE: \_\_\_\_\_ DOSE/FREQUENCY: \_\_\_\_\_

MEDICATION: \_\_\_\_\_ DATE: \_\_\_\_\_ DOSE/FREQUENCY: \_\_\_\_\_

MEDICATION: \_\_\_\_\_ DATE: \_\_\_\_\_ DOSE/FREQUENCY: \_\_\_\_\_

NAME: \_\_\_\_\_ ACCOUNT #: \_\_\_\_\_

10. HAVE YOU EVER SMOKED?: \_\_\_\_\_ HOW MANY PACKS/DAY?: \_\_\_\_\_

HOW LONG DID YOU SMOKE?: \_\_\_\_\_ DO YOU STILL SMOKE?: \_\_\_\_\_

11. DO YOU DRINK ALCOHOL?: \_\_\_\_\_ HOW MUCH/HOW OFTEN?: \_\_\_\_\_

12. PLEASE LIST ANY DISEASES THAT RUN IN YOUR FAMILY: \_\_\_\_\_  
\_\_\_\_\_

13. FATHER: AGE (IF LIVING): \_\_\_\_\_ ILLNESSES: \_\_\_\_\_

AGE (IF DECEASED): \_\_\_\_\_

14. MOTHER: AGE (IF LIVING): \_\_\_\_\_ ILLNESSES: \_\_\_\_\_

AGE (IF DECEASED): \_\_\_\_\_

15. ANY SIGNIFICANT ILLNESSES OF SIBLINGS: \_\_\_\_\_  
\_\_\_\_\_

16. PLEASE SELECT ANY ILLNESSES FOR WHICH YOU HAVE BEEN TREATED:

ASTHMA: \_\_\_\_\_ HIGH BLOOD PRESSURE: \_\_\_\_\_ TUBERCULOSIS: \_\_\_\_\_

THYROID DISEASE: \_\_\_\_\_ EPILEPSY: \_\_\_\_\_ HEART CONDITION: \_\_\_\_\_

URINARY INFECTION: \_\_\_\_\_ DIABETES: \_\_\_\_\_ DEPRESSION: \_\_\_\_\_

RHEUMATIC FEVER: \_\_\_\_\_

17. ANY OTHER IMPORTANT INFORMATION?: \_\_\_\_\_  
\_\_\_\_\_

THE QUESTIONS BELOW PERTAIN TO THE PREVIOUS SIX MONTHS:

1. HAVE YOU LOST WEIGHT?: \_\_\_\_\_ HOW MUCH?: \_\_\_\_\_

2. HAVE YOU HAD A FEVER, CHILLS, OR NIGHTSWEATS?: \_\_\_\_\_

3. HAVE YOU FELT LETHARGIC, EASILY TIRED?: \_\_\_\_\_

4. HAVE YOU BEEN DEPRESSED?: \_\_\_\_\_

5. HAVE YOU HAD SEVERE HEADACHES?: \_\_\_\_\_

6. HAVE YOU HAD VISION PROBLEMS?: \_\_\_\_\_

7. HAVE YOU HAD DIZZINESS OR VERTIGO?: \_\_\_\_\_

8. HAVE YOU HAD PROBLEMS WITH YOUR HEARING?: \_\_\_\_\_

9. HAVE YOU HAD NOSE BLEEDS?: \_\_\_\_\_

10. HAVE YOU HAD PROBLEMS WITH YOUR TEETH AND GUMS?: \_\_\_\_\_

11. DO YOU HAVE DENTURES OR PARTIAL PLATES?: \_\_\_\_\_

12. DO YOU HAVE A SORE THROAT?: \_\_\_\_\_

13. DO YOU HAVE SWOLLEN GLANDS?: \_\_\_\_\_

NAME: \_\_\_\_\_ ACCOUNT #: \_\_\_\_\_

14. DO YOU HAVE THYROID PROBLEMS?: \_\_\_\_\_

15. DO YOU HAVE DIFFICULTY SWALLOWING?: \_\_\_\_\_

16. DO YOU HAVE SHORTNESS OF BREATH?: \_\_\_\_\_

17. DO YOU HAVE CHEST PAIN?: \_\_\_\_\_

18. DO YOU WAKE UP AT NIGHT WITH SHORTNESS OF BREATH?: \_\_\_\_\_

19. DO YOU GET SHORTNESS OF BREATH WITH MINIMAL EXERCISE?: \_\_\_\_\_

20. HOW MANY PILLOWS DO YOU SLEEP ON?: \_\_\_\_\_

21. DO YOU HAVE A COUGH?: \_\_\_\_\_

22. HAVE YOU COUGHED UP ANY BLOOD?: \_\_\_\_\_

23. HAVE YOU HAD ANY NAUSEA OR VOMITING?: \_\_\_\_\_

24. HAVE YOU HAD STOMACH PAIN?: \_\_\_\_\_

25. HAVE YOU HAD CONSTIPATION?: \_\_\_\_\_

26. HAVE YOU HAD DIRRHEA?: \_\_\_\_\_

27. HAVE YOU HAD BLEEDING WITH BOWEL MOVEMENTS?: \_\_\_\_\_

28. HAVE YOU HAD RECTAL PAIN?: \_\_\_\_\_

29. HAVE YOU HAD HEMMORHOIDS?: \_\_\_\_\_

30. HAVE YOU HAD BURING WITH URINATION?: \_\_\_\_\_

31. HOW MANY TIMES PER NIGHT DO YOU GET UP TO URINATE?: \_\_\_\_\_

32. DO YOU STRAIN TO URINATE?: \_\_\_\_\_

33. DO YOU HAVE BLOOD IN YOUR URINE?: \_\_\_\_\_

34. DO YOU HAVE MUSCLE PROBLEMS?: \_\_\_\_\_

35. DO YOU HAVE NERVE PROBLEMS?: \_\_\_\_\_

36. DO YOU HAVE ARTHRITIS OR ACHING JOINTS?: \_\_\_\_\_

37. HAVE YOU EVER HAD A SEIZURE?: \_\_\_\_\_

38. HAVE YOU EVER HAD A STROKE?: \_\_\_\_\_

39. HAVE YOU EVER HAD A HEART ATTACK?: \_\_\_\_\_

**FOR FEMALES**

1. WHEN WAS YOUR LAST MENSTRUAL PERIOD?: \_\_\_\_\_

2. DO YOU HAVE REGULAR/NORMAL PERIODS?: \_\_\_\_\_

3. DO YOU HAVE VAGINAL DISCHARGE?: \_\_\_\_\_

4. HAVE YOU TAKEN OR ARE YOU NOW TAKING ORAL CONTRACEPTIVES?: \_\_\_\_\_

5. DO YOU HAVE AN I.U.D. IN PLACE?: \_\_\_\_\_

6. WHO IS YOUR GYNECOLOGIST?: \_\_\_\_\_

# PATIENT AUTHORIZATIONS:

NAME: \_\_\_\_\_ ACCOUNT #: \_\_\_\_\_

## \_\_\_\_\_ (INIT) ASSIGNMENT OF BENEFITS:

I request that payment of authorized insurance benefits be made either to me or on my behalf to Katy Internal Medicine Associates. I authorize any holder of medical information about me to release to the Healthcare Financing Administration (HCFA) and its agents, or to my insurance company and its agents, any information needed to determine these benefits or the benefits payable for related services. This authorization applies to all insurance carriers on my medical record. I authorize payment to be made to Katy Internal Medicine Associates and further authorize medical information about me to be released to any Medigap insurer or secondary carrier necessary to determine these benefits of the benefits payable for related services. I understand that if benefits are not authorized or payable by my insurance company, for reasons such as claims denied due to insurance not in force at the time services are rendered, or non-covered services, in addition to copayments and/or deductibles are the sole responsibility of the patient and will be payable upon notification from the insurance company that payment is denied. This authorization in its entirety shall remain in effect indefinitely unless written notice is received to revoke such authorizations by the insured/patient. All HIPAA rules and regulations as set forth by law will apply.

## \_\_\_\_\_ (INIT) HIPAA – AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Please list any family members or other person(s) who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual. We will continue to rely on the information on this form when communication with family members or other person(s) involved in your care unless you request changes in writing. Please promptly notify your physician’s office if you wish to alter the designations below.

Name:	Relationship:	All	Sched. Appts.	Medical Info.	Billing/Insurance
_____	_____	( )	( )	( )	( )
_____	_____	( )	( )	( )	( )

## \_\_\_\_\_ (INIT) ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed and/or have had the opportunity to review 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.

*To revoke any or part of any of the above authorizations, please send a written request with a copy of this form to HIPAA Compliance Officer: Roy Spradlin, Katy Internal Medicine Associates, 1331 W. Grand Parkway North, Ste. 230, Katy, Texas 77493-2711*

\_\_\_\_\_  
Signature of Patient/Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

DAVID W. REININGER, M.D., P.A.  
RAMON A. SOLIS, JR., M.D., P.A.  
MUKESH N. MEHTA, M.D., P.A.  
M. JOHN CHUNG, M.D., P.A.  
V. KALAPATAPU, M.D., P.A.



1331 W. Grand Parkway North  
Suite 230  
Katy, TX 77493  
Phone: 281-392-8620  
Fax: 281-392-2258

## FINANCIAL POLICY OF KATY INTERNAL MEDICINE ASSOCIATES, L.L.P.

Thank you for choosing Katy Internal Medicine Associates, L.L.P. to provide your health care. Our main concern is that you receive the proper treatment needed. In order to prevent any misunderstandings and to serve you better, we ask that all patients read and sign our financial policy. If you have any questions or concerns about our policies, please do not hesitate to ask.

1. As a courtesy, we will file your insurance if you are a member of an insurance plan with which we are contracted. If you are not able to provide us with a valid insurance card and we are unable to verify your insurance coverage for any reason, you will be required to pay cash for your visit. If your insurance has changed since your last visit, please inform us BEFORE your visit, and present us with your new card so that we may verify your coverage and benefits. Please be aware that verification of new insurance coverage may incur an additional wait time while we contact your insurance. If you do not inform us of any changes and/or we have not been able to verify your insurance coverage at the time of service, you will be responsible for any unpaid balance. Most insurance plans require that a claim be filed within 90 days from the date of service. Please remember that all charges are your responsibility, whether or not your insurance pays.

PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED. WE ACCEPT CASH, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, AND PERSONAL CHECK.

2. FIXED CO-PAYS ARE COLLECTED WHEN YOU CHECK OUT WITH THE RECEPTIONIST. Deductibles, copays, co-insurance, and non-covered services must be paid at the time service is provided.

3. Charges incurred that are subject to a yearly deductible are due at the time of service. Deductibles and co-insurance amounts are determined and due prior to any procedure being performed. Any overpayments will be refunded after we have received an Explanation of Benefits from your insurance advising us of the allowed amount.

4. MEDICARE PATIENTS: It can be considered Medicare fraud to waive deductibles and co-payments. Therefore, you will be billed for these amounts at the time services are rendered. If you have no secondary insurance coverage, you will be responsible for your 20% co-insurance at the time of the visit.

5. RETURNED CHECKS will incur a \$25.00 returned check fee. The amount of the check plus the fee must be paid within 7 (seven) days of notification by money order, cash, or credit card to prevent further action with the Fort Bend District Attorney. If a second check is returned on your account, we will no longer be able to accept personal checks as payment.

6. COPIES OF LAB RESULTS AND/OR BILLING STATEMENTS require a \$5.00 fee for processing of your requested information. Copies will be available for pick-up or may be mailed at your request only after payment has been received.

7. COPIES OF MEDICAL RECORDS requires a fee of \$25.00 for the first 20 pages, plus \$0.15 per page thereafter, plus the cost of record retrieval for old charts (if applicable) stored on premises of \$13.00 per chart. Records forwarded directly to another physician for continued medical care are provided free of charge.

---

PATIENT/GUARANTOR SIGNATURE

---

DATE