Physician Name: Omer A. Ilahi, M.D.

PATIENT DEMOGRAPHIC INFORMATION SHEET

Last Name | **First Name** | **Middle** | **Social Security No.**

Date of Birth | **Age** | **Male or Female** *(Please circle one)* | **Marital Status: M S W D** *(Please circle one)*

Home Address | **City** | **State** | **Zip**

Home Phone | **Work Phone** | **Cell Phone**

Contact Preference: *(Please Check One)* **Home** **Work** **Cell** **Mail** | **Email Address**

Referred By: | **Phone #:**

EMERGENCY CONTACT INFORMATION

Name | **Phone No.** | **Alt. Phone** | **Relationship**

PATIENT EMPLOYER INFORMATION

Employer Name | **Phone** | **Fax**

Address | **City** | **State** | **Zip**

GUARANTOR / POLICY HOLDER INFORMATION

Last Name | **First Name** | **Middle** | **Social Security No.**

Date of Birth | **Patient's Relationship to Policy Holder** | **Home Phone** | **Cell Phone**

Employer Name | **Phone** | **Fax**

Employer Address | **City** | **State** | **Zip**

INSURANCE INFORMATION

Primary Insurance	**Name of Primary Insurance**	**ID/Policy Number**	**Group Number**	**Customer Service No.**
Secondary Insurance	**Name of Secondary Insurance**	**ID/Policy Number**	**Group Number**	**Customer Service No.**
Work Comp Insurance	**Name of WC Insurance**	**Claim #**	**Adjuster Name**	**Adjuster Phone No.**

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR HIS SERVICES. I UNDERSTAND THAT THIS AUTHORIZATION DOES NOT RELEASE ME FROM MY PERSONAL RESPONSIBILITY FOR PAYMENT OF ALL CHARGES WITHIN 50 DAYS. **AUTHORIZATION TO RELEASE INFORMATION:** I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OF TREATMENT.

Signature: | **Date:**

Omer A. Ilahi, M.D.

Medical History Questionnaire

Please complete this form to help us identify factors that could cause or contribute to your current conditions, or that could affect your recovery. It is especially important to list all of your current medications and all medications which cause you to have an allergic reaction.

NAME:_____ DATE OF BIRTH:_____ OCCUPATION:_____

WHAT ARE YOU HERE TO SEE THE DOCTOR FOR?: _____

HAVE YOU HAD ANY X-RAYS OR IMAGING OF THE INJURED AREA? _____ WHERE? _____

IS THIS THE RESULT OF AN ACCIDENT? YES_____ NO_____ PERSONAL? _____ WORK RELATED? _____

WHO REFERRED YOU TO THIS OFFICE? _____

NAME OF FAMILY PHYSICIAN_____ DATE LAST SEEN? _____

HEIGHT _____ WEIGHT_____ PHARMACY: _____ PHONE #:_____

MEDICATIONS **YOU** ARE CURRENTLY TAKING: _____

_____

_____

MEDICATION ALLERGIES & REACTIONS: _____

PREVIOUS SURGERIES **YOU** HAVE UNDERGONE: _____

_____

FAMILY HISTORY OF DISEASES/CONDITIONS: _____

DO **YOU**: SMOKE? FORMER: _____ NEVER: _____ YES:_____ PACKS PER DAY: _____

DRINK ALCOHOL? NO: _____ YES: _____ HOW OFTEN? _____

DO **YOU** HAVE ANY PROBLEMS WITH:

	CIRCLE		DESCRIBE ALL **YES** RESPONSES.
ANESTHESIA	YES	NO	_____
BLEEDING PROBLEMS	YES	NO	_____
BLOOD CLOTS	YES	NO	_____
CANCER	YES	NO	_____
CHOLESTEROL	YES	NO	_____
DIABETES	YES	NO	_____
EPILEPSY / SEIZURES	YES	NO	_____
EYES / VISION	YES	NO	_____
HEART	YES	NO	_____
HIGH BLOOD PRESSURE	YES	NO	_____
LIVER / HEPATITIS	YES	NO	_____
LUNGS / BREATHING	YES	NO	_____
SLEEP APNEA	YES	NO	_____
STOMACH ULCERS / DIGESTIVE	YES	NO	_____
STROKE	YES	NO	_____
THYROID	YES	NO	_____

OTHER MEDICAL PROBLEMS: _____

_____

SIGNATURE: _____ DATE: _____

SOUTHWEST ORTHOPEDIC GROUP, LLP

Review of Notice of Privacy Practices

Acknowledgement:

I acknowledge that 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.

_____ _____

Patient or Personal Representative **Date**

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: _____.

Financial Policy Statement

It is the policy of Southwest Orthopedic Group, LLP, to bill your insurance carrier as a courtesy to you; however, you are responsible for the entire bill. We require that arrangements for payment of your estimated share be made today. The insured/patient is responsible for any co-payments at the time service is rendered. If your insurance carrier does not remit payment within sixty (60) days, the balance will be due in full from you. If your insurance pays in excess of the balance of your account, we will refund the credit.

If any payment is made directly to you for services billed by Southwest Orthopedic Group, LLP, you recognize an obligation to promptly remit payment to Southwest Orthopedic Group, L.L.P.

The above does not apply to those patients that are considered Workers' Compensation. However, be advised as a Workers' Compensation patient that you may be held responsible for your charges in the event that your claim is controverted.

I understand and agree that if I fail to make any of the payments for which I am responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by Southwest Orthopedic Group, LLP, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

The above information has been read and explained to me. **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

_____ _____

Responsible Party Print Name **Date**

_____

Responsible Party Signature

SOUTHWEST ORTHOPEDIC GROUP, L.L.P.

AUTHORIZATION FOR COMMUNICATION OF MEDICAL INFORMATION

Patient Name: _____ *DOB:* _____

Address: _____ *Telephone#*_____

In order for our practice to respond promptly and accurately to your needs, Please list any person(s) whom you would like to have access to your medical information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that this authorization is valid for 90 days from the date of my signature. I understand that this authorization authorizes the release of all my medical records. I further understand that I can revoke this authorization in writing at any time prior to the expiration date. In addition, I understand that any release of this information by the recipient without my further consent is prohibited. Finally, I understand that a photocopy of this authorization may be considered valid.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

Disclosure of Physician Ownership

Dr. Omer Ilahi has an ownership interest in *Central Houston Surgical Center.*

Dr. Ilahi believes that this interest allows him greater influence over the care provided to his patients.

In the event that you are referred for surgery at this center, you do have the option of using another health care facility if you choose. You will not be treated differently by Dr. Ilahi if you choose a different facility.

If you have any questions or concerns, please feel free to discuss them with Dr. Ilahi or his office staff.

Acknowledgement of Disclosure

Your signature on the bottom of this form signifies that you have read and understand this disclosure and that you know you can direct any questions and/or concerns regarding this disclosure to Dr. Ilahi or his office staff.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Printed Patient Name Time

6560 Fannin, Suite 1016
Houston, Texas 77030
(713) 800-1100

4201 Garth Road, Suite 111
Baytown, Texas 77521
(281) 428-1001

(713) 800-1101 Fax