Patient Information

Patient Name: ______________________________ Date of Birth: ______________

Address: ______________________________________ Apt #: ______________

City: ___________________________ State: ________ Zip: ______________

Home Phone: ________________________ Cell Phone: ________________________

Social Security #: ______________________

Please circle one of the following:

Gender: MALE or FEMALE

Marital Status: SINGLE MARRIED DIVORCED WIDOWED

Please check one of the following:

Ethnicity

- ☐ American Indian/ Alaskan
- ☐ Black/ African American
- ☐ Native American/ Hawaiian
- ☐ Asian
- ☐ White/ Caucasian
- ☐ Two or More Races
- ☐ Some other Race

Please check one of the following:

Race

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐Unknown/Refused

Referring Doctor: ______________________________ Phone #: ____________________

Reason for Referral: ____

Primary Care Physician: __________________________ Phone #: ____________________

If not referred from another physician, where did you hear about us?

- ☐ Sugarland Community Magazine
- ☐ Fort Bend Focus
- ☐ Absolutely Brazos
- ☐ Facebook
- ☐ Internet
- ☐ Other: ______________________

Insurance Information

Primary Insurance: ______________________________ **Phone:** ____________________

Member ID: __________________________ **Group:** ___________________

Insurance Holder *(if different from patient)*: ___________________________ **DOB:** __________

Address: ____ **Apt #:** ______________

City: _______________________________ **State:** _______ **Zip:** ______________

Secondary Insurance: ____________________________ **Phone:** ____________________

Member ID: __________________________ **Group:** ___________________

Emergency Contact Information

Name: ___________________________ **Relationship:** _________________________

Address: __________________________ **City:** _____________ **State:** ____ **Zip:** ________

Home Phone: __________________________ **Cell Phone:** ________________________

I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR THE ENTIRE AMOUNT OF ALL CHARGES OCCURRED BY ME FOR PROFESSIONAL SERVICES BY THIS OFFICE.

Signature: ________________________________ **Date:** _______________________

Medication List

	Name of Medication	Dosage (mg/mcg)	How Many Times per Day	Form (pill, liquid, inj.)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

Signature of patient: ______________________________ **Date:** ______________________

Pharmacy Information

Retail Pharmacy (example: Walgreens, CVS, etc.)

Name: ______________________________

Phone #: ______________________________

Fax #: ______________________________

Address: ____

____

Mail Delivery Pharmacy (example: Medco/Express Scripts, etc.)

Name: ______________________________

Phone #: ______________________________

Fax #: ______________________________

Address: ____

____

Signature: ____ **Date:** ______________________

REQUEST FOR MEDICAL RECORDS RELEASE

Yassir Sonbol, M.D.

Board Certified in Cardiology and Interventional Cardiology

Methodist Office Building #3

11605 Southwest Freeway, Suite# 420 ◊ Sugar Land, TX 77479

TEL: (281) 912-3866 ◊ FAX: (281) 201-6545

The following individual has asked us to request that his or her medical records be released and forwarded to our office.

Patient: ______________________________

Birthdate: ____________________________

Social Security Number___________________

In order for us to fully evaluate the patient's health and make informed decisions, the patient has approved our request for copies of all relevant medical records in your file. Please be sure to include all lab reports as well as office notes.

Thank you for expediting this request. Please mail or fax these records to our office address shown above.

I hereby authorize the release of all necessary medical records to <u>Dr Yassir Sonbol, M.D.</u> I wish for them to be forwarded as soon as possible.

Patient's Signature: ___________________________________ **Date:** _______________

Patient's Address: ______________________________

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

We may use or share your medical information <u>without</u> your permission for the reasons below:

- So you can get medical care. For example, we may share your medical information with your doctors or pharmacies so that they can provide you with appropriate medical care.
- So we can perform our duties. For example: to assess quality of care; to manage your care; or for audits.
- To inform you about other health services.
- To comply with the law.
- For other reasons:
  - To comply with legal proceedings, such as a court or administrative order or subpoena;
  - To enforce other laws or protect someone's health and safety;
  - So a family member, friend or other person can help you to get or pay for your health care;
  - So a personal representative you appoint or a court appoints for you can help you get health benefits;
  - To support research as long as the information will be protected by the researchers;
  - So a coroner or medical examiner can identify a deceased person or cause of death or so a funeral director can arrange burial;
  - To support an organ procurement organization in limited circumstances;
  - To protect you against a serious threat to your health or safety or the health or safety of others;
  - To support a government agency overseeing health care programs;
  - For lawful national security purposes;
  - For public health purposes and for military purposes, if you are a member of the armed forces.

We will not use or share your medical information for any other reason unless you give us written permission. You may withdraw your permission in writing at any time. Your permission for us to use or share your information will end when we get your written notice withdrawing your permission.

Your rights. You may ask us in writing to do any of the following. We will decide if it can be done based on the Privacy Protection Standards outlined in HIPAA.

- You may ask us not to use or share your medical information.
- You may ask we contact you about your medical information privately in a different way or at a different place than we are currently doing.
- You may ask to see or obtain copies of your medical information. You may be charged a fee for copies.
- You may ask us to correct your medical information.
- You may ask for a list of ways we shared your medical information for up to 6 years. We can provide you with information shared on or after April 14, 2003.

Complaints. If you believe we have not protected your right to privacy, you have the right to complain to us or the Secretary of the U.S. Department of Health and Human Services.

We reserve the right to change our privacy practices. If you have any questions, contact us at 281-482-7360.

I understand and accept the terms of these practices:

Signature: ______________________________ Date: ________________