SUGAR LAND FUNCTIONAL MEDICINE

16525 Lexington Blvd Suite #220 Sugar Land, Tx 77479
281-240-2225

CONFIDENTIAL PATIENT INFORMATION

Date: ______________________ Email Address: ____________________________________
Full Name: ____
Name of Wife, Husband, or Guardian: ____
Address: ____
City: ____________________ State: ____________________ Zip Code: __________________
Cell Phone Number: _____________________ Home Phone Number: ______________________
Birth Date: ___________ Male: _________ Female: ________ Marital Status: S __ M __ D __ W __
Number of Children: ______ Currently Pregnant? _________
Occupation: ____
Employer's Name/Phone #: ____
Spouse's Occupation/Employer: ____
Name and Phone # of Emergency Contact: ____
How did you hear about our office? ____
Appointment Reminders? Voice Home _____ Voice Cell ____ Text ____ Email _____ None ________

Primary Complaint(s): ____
Present Symptom(s):____
When Symptoms Startes ___/____/_____ How Symptoms Started: __________________________
Severity of Pain from 1 (mild pain) to 10 (severe pain): ____________________________________
Primary Complaint(s)____
Present Symptom(s)____
What is your pain/condition holding you back from doing (I.e sleeping, exercising, traveling, time with family, hobbies, eating healthy, etc.)

List **ALL** medications and supplements you take. (Prescription and over-the-counter, use additional paper id needed)

Drug Name:	Dosage:	How long have you taken & for what conditions?

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Check **ALL** (symptoms/pain) you may have/had or do have now:

__ADD/ADHD	__Depression	__Hepatitis	__Miscarriage
__Alcoholism	__Diabetes	__High Blood Pressure	__Multiple Sclerosis
__Allergy	__Diarrhea	__High Cholesterol	__Neck Pain
__Alzheimer's	__Eczema	__High Blood Sugar	__Parkinson's
__Anemia	__Emphysema	__HIV/AIDS	__Pneumonia
__Appendicitis	__Epilepsy/seizures	__Irregular	__Raynaud's
__Asthma	__Fibromyalgia	__Period/cramps	__Rheumatoid Arth.
__Arthritis	__Gall Bladder	__Irritable Bowel	__Ringing in ears
__Back Pain	__Goiter	__Kidney infections/stones	__Sinus infections
__Cancer	__Gout	__Low Blood Pressure	__Stroke
__Celiac Disease	__Headaches	__Low Blood Sugar	__Thyroid Problems
__Chronic Fatigue	__Heart Attacks	__ Lyme Disease	__Ulcers
__Constipation	__Heart Disease	__Lupus	__Vertigo/dizziness
__Migraine			

Do you consume any of the following? (Leave blank what doesn't apply)

Tobacco products (packs/day) ___________ How many years? ______________

Alcohol (drinks/day) __________________ How many years? ______________

Primary Complaint:____

When did your complaint first begin? ____

What makes your problem better? ____

What makes your problem worse? ____

Describe the type of pain/ symptoms you experience: _____________________________________

Where exactly is the complaint area? ____

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Please list your top 3 major health concerns in order of importance:

1. ____

2. ____

3. ____

AUTHORIZATION & NOTICE OF PRIVACY PRATICES
PATIENT'S AFFIRMATION OF RECEIPT OF PATIENT'S STATEMENT OF PRIVACY RIGHTS--
I hereby acknowledge receipt of this office's Statement of Privacy Rights, provided on my behalf and in accordance with law and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

ASSIGNMENT OF BENEFITS FORM--Financial Responsibility--All professional services rendered are charged to the patient and due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.Assignment of BenefitsI hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, Private Insurance and any other health/medical plan, to issue payment check(s) directly to Sugar Land Functional Medicine for medical services rendered to myself and/ or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.Authorization to Release InformationI hereby authorize Sugar Land Functional Medicine to:(1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing. I have requested medical services from Sugar Land Functional Medicine on behalf of myself and/or my dependents, and understand that by making this request, I have become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

I fully understand that my signature is consent and authorization to be examined by Dr Jeffrey Hogan or the on duty nurse practictioner.

Patient Signature ____ Date ________________