REDDY CARDIAC WELLNESS

PATIENT INFORMATION SHEET/INFORMACION DE PACIENTE

PLEASE PRINT LEGIBLY

Today's Date/Fecha: ___________

Primary Doctor: ____________________

Doctor's Phone #: __________________

Last Name/Apellido: _________________ **First Name**/Nombre: ____________________

Address/Direccion: ____

City/Ciudad: _____________ **State**/Estado: ________ **Zip Code**/Codigo postal: ________

Phone No./Telefono: (______)______________ **Alt Phone No.:** (______)______________

Date of Birth/Fecha de nacimiento: ________________ **Gender**/sexo: MALE / FEMALE

Social Security # / #de seguro social: ________________________

Marital Status: Single / Soltero(a) Married/Casado(a) Divorced/Divorciado(a) Widowed/ Viudo(a)

Work-Status: Unemployed/Sin Empleo Part-Time Full-time Self-Employed/Empleado porsi mismo Retired/ Retirado

Employer Name/Nombre de Empleo: ____

Work Phone No./ # telefono de empleo: ______________________________________

How Did You Hear About Us? Physician Friend/Patient Internet Newspaper Magazine DVD

Name of Referral Source: ___________________

INSURANCE INFORMATION/ INFORMACION DE SEGURO

Insurance Company/Compania de Seguro: ______________________________________

Phone No/ # de telefono: (________)____

Secondary Insurance Company/Seguro secundario: ______________________________

Phone No/ # de telefono: (________)____

POLICY HOLDER INFORMATION

Relationship to patient/Relacion al paciente: **Self** / Yo mismo* **Parent**/ Padres **Spouse**/ Esposo

*If self, disregard completing the following information/Si es Yo, no tiene que completar la informacion de abajo.

Last Name/Apellido: ____________________ **First Name**/Nombre: ____________________

Address/ Direcion: ____

City/Ciudad: __________________ **State**/Estado: ________ **Zip Code**/Codigo postal: __________

Phone No./Telefono: (______)______________ **Date of Birth**/Fecha de nacimiento: __________

Social Security # / #de seguro social: ____

Employer Name/Nombre de Empleo: ____

Work Phone No./ # telefono de empleo: ____

REDDY CARDIAC WELLNESS

3519 Town Center Blvd S #A• Sugar Land, TX 77479•PH (281) 491-0044• FAX (281) 491-1802

MEDICATION LIST

PATIENT NAME: ______________________________ DATE OF BIRTH: ____________

PHARMACY PH#: ______________________________ PHARMACY: ________________

ALLERGIC TO: ____

PLEASE LIST ALL MEDICATIONS AND DOSES:

NAME DOSE TAKEN HOW OFTEN?

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____

NOTES: ____

REDDY CARDIAC WELLNESS

SLEEP DISORDER QUESTIONNAIRE

If you have one or more of the following symptoms, you probably have a sleep disorder called "sleep apnea" and may need a sleep study. Please check all that apply:

- ☐ Snoring
- ☐ Problem sleeping (Insomnia) or restless sleep
- ☐ Gasping for breath or choking, after a pause in breathing
- ☐ Daytime sleepiness
- ☐ Morning headaches
- ☐ Fatigue, loss of energy
- ☐ Sexual dysfunction (i.e. Impotence, lack of desire)
- ☐ Forgetfulness or trouble concentrating
- ☐ Irritability or mood changes
- ☐ Anxiety or depression
- ☐ Overweight
- ☐ Large neck size
- ☐ High blood pressure
- ☐ Drowsy while driving
- ☐ Waking up with a dry mouth
- ☐ Frequent leg jerks/movements or restless legs
- ☐ Heartburn
- ☐ Frequent trips to the bathroom at night
- ☐ Excessive night sweating

Patient Name:______________________________ Date of Birth:__________

Date:____________________

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COPAYS, DEDUCTIBLES AND CO-INSURANCE AGREEMENT.

PATIENT COPAYS AND DEDUCTIBLE MUST BE COLLECTED AT THE TIME OF SERVICE PER THE TEXAS INSURANCE CODE (ARTICLE 21.24-1). THE TEXAS OCCUPATIONS CODE (SECTION 101.203) AND THE HEALTH AND SAFETY CODE (SECTION 311.0025) STATE IT IS FRAUDULENT FOR A PHYSICIAN TO SUBMIT AN INSURANCE CLAIM THAT DOES NOT DISCLOSE A PLAN TO WAIVE PATIENTS COPAYS, CO-INSURANCE OR DEDUCTIBLES AMOUNTS. IF YOU ARE NOT AWARE OR DO NOT AGREE WITH THE AMOUNT(S), PLEASE CONTACT YOUR CARRIER. IF YOU ARE DISPUTING THE VERIFIED AMOUNTS, WE WILL NOTIFY YOUR INSURANCE THAT YOU ARE IN VIOLATION WITH YOUR CONTRACTUAL AGREEMENT AND FURTHER ACTION WILL BE TAKEN IF NECESSARY. YOUR INSURANCE MAY THEN CHOSE THAT YOU PAY YOUR DEDUCTIBLE AMOUNTS DIRECTLY TO THEM OR YOUR MEDICAL PLAN COVERAGE MAY BE TERMINATED FOR NON-COMPLIANCE.

I,______________________________, AM AWARE OF MY CO-PAY, CO-INSURANCE AND/OR DEDUCTIBLE AMOUNT(S). REDDY & REYNOLDS CARDIOLOGY ASSOCIATES AGREES TO ADJUST ALL CONTRACTED AMOUNTS AS PER THEIR MANAGED CARE CONTRACT WITH MY CARRIER. I WILL BE BILLED FOR ANY AMOUNTS MY INSURANCE STATES AS MY RESPONSIBILITY.

SIGNATURE: ______________________________DATE: _______________

REDDY CARDIAC WELLNESS

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize payment directly to the physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described, realizing I am responsible to pay non-covered services.

SIGNATURE ______________________

DATE ______________

AUTHORIZATION TO RELEASE INFORMATION:

I herby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

SIGNATURE ______________________

DATE ______________

Acknowledgement of Review of Notice of Privacy Practices:

I have been given the opportunity to review this office's Notice of Privacy Practices, which explains how my medica information will be used and disclosed. I understand that I am entitled to receive a copy of this document, which is available to me upon request.

Signature of Patient or Personal Representative ______________________

DATE ______________

Name of Patient or Personal Representative ______________________

Description of Personal Representative's Authority ______________________

Reconocimiento de Repaso del Aviso de Prácticas de Privacidad:

Afirmo que he repasado el Aviso de Prácticas de Privacidad de esta clínica, el que explica en qué manera s utilizarán y compartirán mis datos médicos. Entiendo que tengo derecho a solicitar y que se me sea entregada ur copia del Aviso de Prácticas de Privacidad.

Firma del paciente o su Representante ______________________

Fecha ______________

Nombre del paciente o su Representante ______________________

Descripción de la autoridad del Representante ______________________