

Print Name: _____

Date: _____

Medical Questionnaire

PLEASE ANSWER ALL QUESTIONS. DO NOT LEAVE ANY BLANKS

Do you have a history of:

Please circle all items

- | | | | |
|--------|--|--------|-------------------------|
| Y or N | Asthma | Y or N | Phlebitis "blood clots" |
| Y or N | Diabetes | Y or N | Blood Transfusion |
| Y or N | Migraines | Y or N | Thyroid disease |
| Y or N | Heart Disease | Y or N | Wound healing problems |
| Y or N | High Blood Pressure | Y or N | Anemia |
| Y or N | Epilepsy | Y or N | Steroids/Prednisone |
| Y or N | Seizures | Y or N | Stroke |
| Y or N | Kidney Disease | Y or N | Hepatitis |
| Y or N | Diet Pills/Herbal Supplements: Type _____ | | |
| Y or N | Mammogram: When _____ Physician _____ | | |
| Y or N | MRSA/Staph: When _____ Treatment _____ | | |
| Y or N | Pain Medication Dependency: Type _____ Treatment _____ | | |
| Y or N | Psychiatric Illnesses: Type _____ Treatment _____ | | |

Hospitalization/Surgeries:

	Date	Type of Surgery	Place of Surgery	Physician
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

If more, please list on back of sheet

Family History of:

Please check all that apply:

- (__ Heart Disease; relationship_____) (__ Diabetes; relationship_____)
 (__ Cancer; relationship_____) (__ Other not listed_____; relationship_____)

- Do you:** Smoke: Y or N, How much _____
 Use Alcohol: Y or N, How often _____
 Use Recreational drugs: Y or N Type _____
 Walk with a walker or cane: Y or N _____

Current Medications: over the counter, herbal, nutritional, etc.

Medication Name:	Dose:	Frequency:	Last Dose Taken:

If more, please list on back of sheet

Allergies: _____

Patient Registration (Insurance)
PLEASE FILL IN ALL BLANKS

Date: _____

GENERAL INFORMATION:

Marital Status: Single Divorced Married Widowed

Mr. Mrs. Ms. Miss Dr.

Patient's Name: _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____

Home: _____ Work: _____

Cell Phone #: _____

Primary Care Dr.: _____ Office #: _____

Social Security #: _____ Date of Birth: _____

Patient's Employer: _____

How did you hear about us? Friend/Family _____ Internet Insurance Magazine

Doctor _____ Existing Patient _____ Other _____

SPOUSE INFORMATION:

Spouse: _____ Spouse Contact#: _____

Spouse DOB _____ Spouse SSN: _____

Spouse Employer: _____ Work#: _____

INSURANCE INFORMATION:

PRIMARY 1: _____ ID/SSN: _____

Subscriber: _____ Group or Policy #: _____

SECONDARY 2: _____ ID/SSN: _____

Subscriber: _____ Group or Policy #: _____

DOB: _____ Sex: M F

**** If non-payment by insurance in (60) days, patients are responsible for unpaid fees.***

Signature: _____ Date: _____

Robert D. Peterson M.D., Ltd., LLP
17070 Red Oak Dr. Ste., 500
Houston, TX 77090
Ph.:281-893-4144 Fax: 281-583-2375

Robert Dickey Peterson, M.D. LLP, LLC

Insurance

Our office will file your insurance claims for you for certain medical procedures. As a courtesy we will file claims for out of network insurance companies for certain medical procedures, but be aware that your deductible and out of pocket responsibility may be higher for not using an in network provider. The balance is your responsibility whether your insurance company pays or not. **Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 60 days, the balance will automatically be transferred to you as the guarantor.** Please be aware that some, and perhaps all, of the services provided may be non-covered services and may not be considered reasonable and necessary under Medicare Program and / or other medical insurance. We will notify you of this and have you sign proper paper work.

Usual and Customary Rates

Our practice is committed to providing the best treatment for all patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

PHOTOGRAPHIC CONSENT

The following is my consent for Dr. Peterson or a staff representative to photograph me for the following purposes. *Using respectful and discretionary measures, the photographs may be viewed by medical health care professionals, as well as non-medical individuals.*

Patient's file Photographs are required for the patient's file and will be utilized for comparative review during the course of treatment.

Office reference These photographs may be used for educational purposes.

Internet The discreet use of photographs may be used exclusively on Dr. Peterson's educational website.

By signing, I am granting Dr Peterson permission to use my photographs as checked above.

Signature

Date

I have reviewed the office's Notice of Privacy Practice, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Robert D. Peterson M.D., Ltd., LLP
17070 Red Oak Dr. Ste., 500
Houston, TX 77090
Ph.:281-893-4144 Fax: 281-583-2375