dba CI Medical Center

(Center for Integrated Medicine)

8278-A Bellaire Blvd.; Houston, TX 77036

https://www.cimedicalcenter.com/

Tel: 713-272-8858 - Fax: 713-995-6142

Please fill out ALL of the information below so that we can verify your insurance benefits. If you have any questions, please do not hesitate to contact us. Thank you.

PATIENT INFORMATION DATE: (mm/dd/yyyy)

Name _____ (First Name) _____ (Last Name) _____ (Middle Initial) Date of Birth _____ (mm/dd/yyyy) Age _____

Address _____ City _____ State _____ Zip Code _____

Phone home _____ Work _____ Cellular _____

Email _____

Driver's License No _____ State _____

Sex ◯ Male ◯ Female ***Marital Status*** ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed

Occupation _____

Spouse's name (parent's name, if child) _____

How did your hear about us? ◯ Family ◯ Friend ◯ Internet ◯ Health Plan ◯ Banner ◯ Radio ◯ Other _____

☐ **SELF PAY** (if self pay, skip INSURANCE VERIFICATION section below)

Pharmacy Information

Name of Pharmacy _____

Address of Pharmacy _____

Phone of Pharmacy _____

Race & Ethnicity ◯ White ◯ Black ◯ Hispanic or Latino ◯ Asian ◯ Native Hawaiin ◯ American Indian

PRIMARY INSURANCE INFORMATION

Name of Carrier _____

Phone Number of Insurance _____

Insured Subscriber ID Number _____

Insured Subscriber Group Number _____

Patient's Relationship to the Insured ◯ Self ◯ Spouse ◯ Child ◯ Other _____

SECONDARY INSURANCE INFORMATION

Name of Carrier _____

Phone Number of Insurance _____

Insured Subscriber ID Number _____

Insured Subscriber Group Number _____

Patient's Relationship to the Insured ◯ Self ◯ Spouse ◯ Child ◯ Other _____

HEALTH HISTORY: INITIAL EXAM

NAME		DATE OF BIRTH		SEX		AGE	

(mm/dd/yyyy)

HISTORY OF PAST ILLNESS

PERSONAL	*No*	*Yes*	***VACCINATIONS***	*No*	*Yes*	*If yes, date:*
Cancer	☐	☐	Influenza / Flu	☐	☐	
Diabetes	☐	☐	Pneumovax	☐	☐	
Heart Disease	☐	☐	Tetanus (Td or DTP)	☐	☐	
Hight Blood Pressure	☐	☐	Zoster or Shingles Vaccine	☐	☐	
Stroke	☐	☐	Hepatitis A (2 vaccines in 6 months)	☐	☐	
Lung Disease	☐	☐	Hepatitis B (3 vaccines in 6 months)	☐	☐	
Asthma	☐	☐	Typhoid	☐	☐	
Renal Disease	☐	☐	Other	☐	☐	
Glaucoma	☐	☐	HPV (3 vaccines in 6 months)	☐	☐	
Anemia or blood disease	☐	☐	Yellow Fever	☐	☐	
Seizures or Convulsions	☐	☐	MMR	☐	☐	
Cholesterol	☐	☐	Chicken Fever	☐	☐	
Sleep apnea	☐	☐	Polio	☐	☐	
Mental Illness	☐	☐	PPD or tuberculosis skin test	☐	☐	
Other	☐	☐	PPD Result: ☐ Negative or ☐ Positive ☐ Date of Result			

HEALTH MAINTENANCE AND PROCEDURES (circle yes or no)

Have you ever had:	*Response*		*If Yes, Date:*	*Was the Result Normal?*		*If results are NOT normal, explain:*
	Yes	*No*		*Yes*	*No*	
Colonoscopy	☐	☐		☐	☐	
EGD or Upper endoscopy	☐	☐		☐	☐	
Treadmill stress test (TMST)	☐	☐		☐	☐	
Nuclear Treadmill stress test	☐	☐		☐	☐	
Echocardiogram (Echo)	☐	☐		☐	☐	
Angiogram	☐	☐		☐	☐	
Other	☐	☐		☐	☐	
Mammogram	☐	☐		☐	☐	
PAP Smear	☐	☐		☐	☐	
Bone density or DEXA	☐	☐		☐	☐	

Name of Medicine	***Start***	***Dose***	***Frequency Per Day***

MEDICATION / ALLERGIES

Allergies or reactions to food or medication:	☐ No Known Drug Allergies

PAST MEDICAL HISTORY	Response		If Yes, Date	Reason for Hospitalization
Have you ever been HOSPITALIZED?	☐ Yes	☐ No		
#1				
#2				
#3				
#4				
Prior SURGERY	☐ Yes	☐ No		
#1				
#2				
#3				
#4				

FAMILY HISYORY (check appropriate box for family history)

	Alive	*Deceased*	*Age*	*Healthy*	*Diabetes*	*Hypertension*	*Heart Disease*	*Lung DZ*	*Stroke*	*Cancer*	*Comment*
Father	☐	☐		☐	☐	☐	☐	☐	☐	☐	
Mother	☐	☐		☐	☐	☐	☐	☐	☐	☐	
☐ Daughter ☐ Son	☐	☐		☐	☐	☐	☐	☐	☐	☐	
☐ Daughter ☐ Son	☐	☐		☐	☐	☐	☐	☐	☐	☐	
☐ Daughter ☐ Son	☐	☐		☐	☐	☐	☐	☐	☐	☐	
☐ Daughter ☐ Son	☐	☐		☐	☐	☐	☐	☐	☐	☐	
☐ Daughter ☐ Son	☐	☐		☐	☐	☐	☐	☐	☐	☐	
☐ Brother ☐ Sister	☐	☐		☐	☐	☐	☐	☐	☐	☐	
☐ Brother ☐ Sister	☐	☐		☐	☐	☐	☐	☐	☐	☐	
☐ Brother ☐ Sister	☐	☐		☐	☐	☐	☐	☐	☐	☐	
☐ Brother ☐ Sister	☐	☐		☐	☐	☐	☐	☐	☐	☐	
Relative	☐	☐		☐	☐	☐	☐	☐	☐	☐	
Relative	☐	☐		☐	☐	☐	☐	☐	☐	☐	
Relative	☐	☐		☐	☐	☐	☐	☐	☐	☐	

SOCIAL HISTORY

Marital Status: ○ Single ○ Married ○ Separated ○ Divorced ○ Windowed
Occupation:
Education Level:
Use of Tobacco: ☐ Never ☐ Yes, how much? ☐ # of years: ☐ Quit for year
Use of Alcohol: ☐ Never ☐ Yes, how much? ☐ # of years:
Use of Street Drugs: ☐ Never ☐ If yes, describe:
Physical Activities: ☐ Active ☐ yes ☐ No ☐ If yes, # of times per week: ☐ Limited due to:
Any religious/cultural practices that would affect your care:

REVIEW OF SYSTEM

	Check any that apply or "none"
Neuro	☐ None ☐ Headache ☐ Convulsions ☐ Seizures ☐ Fainting ☐ ADD ☐ Stroke ☐ Other
Psych	☐ None ☐ Depression ☐ Anxiety ☐ Stress/Excess Worry ☐ Drug/Alcohol Issues ☐ Other
Eyes	☐ None ☐ Visual Problems ☐ Blurry Vision ☐ Red Eyes ☐ Eye Pain ☐ Other
Nose	☐ None ☐ Nasal Allergies ☐ Chronic Sinusitis ☐ Frequent nose bleed ☐ Other
Ears	☐ None ☐ Hearing problems ☐ Ringing in the ears ☐ Discharge ☐ Other
Throat	☐ None ☐ Swallowing difficulty ☐ Frequent sore throats ☐ Speech problems ☐ Other
Mouth	☐ None ☐ Dental problems ☐ Tongue problems ☐ Canker sores ☐ Other
Neck	☐ None ☐ Swollen glands ☐ Thyroid problems ☐ Other
Chest	☐ None ☐ Chest pain ☐ Asthma ☐ Shortness of breath ☐ Chronic cough ☐ + TB Test ☐ Other
Heart	☐ None ☐ Murmurs ☐ Palpitations ☐ Valve problems ☐ Mitral Valve problem ☐ Angina ☐ Other
Intestinal	☐ None ☐ Heartburn ☐ Reflux ☐ Colitis † Gastritis ☐ Polyps ☐ Constipation ☐ Bleeding ☐ Other
Urinary & Genital	☐ None ☐ Frequency ☐ Burning ☐ Kidney Stones ☐ Infection or STD ☐ Erectile dysfunction ☐ Urinary stream
Extremity and spine	☐ None ☐ Pain in: ☐ arm ☐ wrist/hand ☐ shoulder ☐ ankle ☐ neck ☐ mid back ☐ herniated disk
Systemic	☐ None ☐ Weight loss ☐ Fever ☐ Night sweats ☐ Trouble sleeping ☐ Loss of energy ☐ Arthritis

CONSENT TO MEDICAL TREATMENT

I hereby authorize Center for Integrated Medicine (dba CI Medical Center), its employees, agents and otherwise affiliates to administer any treatment, and perform such other actions as the physician may deem necessary or advisable in my diagnosis and treatment. I am aware that the practice of medicine is not an exact science and I acknowledge that no warranty, guarantee or assurance has been made by the clinic or physician as to the results of the treatments, examination or otherwise that may be obtained.

ASSIGNMENT OF INSURANCE BENEFITS TO PROVIDER

I hereby request payment and assign any benefits due me under the terms of any policy or policies and/or under Title XVIII of the Social Security Act that may cover professional services rendered to the above name mentioned assignee.

FINANCIAL AGREEMENT

I agree to pay any balance of the charges over and above the above mentioned benefits. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of any information to any insurance company or third party payor for the purpose of obtaining payment for services provided. I authorize release of any information to any physicians, skilled facility or other health care facility to which I may be admitted or that is involved in my medical care.

Emergency Contact [*I agree to release my protect health information to my emergency contact*]	
Name	_____
Relationship	_____
Phone Number	_____

PATIENT / RESPONSIBLE PARTY SIGNATURE:	DATE:

(mm/dd/yyyy)