DR. VICTOR O. MENDIOLA, M.D.
427 W. 20TH ST. STE. #503
HOUSTON, TX 77008

PATIENT INFORMATION

Patient Name:			
Responsible Party (If Minor):			
Email:		Would you like access to the Patient Portal?	
Date Of Birth:	Age:	Sex:	SSN# :
Address:	City:	State:	Zip:
Home Phone:	Cellular Phone:	Work Phone:	
Marital Status:			
Spouse Name:			
Spouse's Date Of Birth:		Spouse's SSN #	
Business Address:		Business Phone:	

Patient (Or Parent – If Minor) Employer Information

Patient's Employer:		Occupation:	
Employer's Address:	City:	State:	Zip:
Employer's Phone Number:			

Insurance Information

Who Is Responsible For This Account:		Relationship to Patient:
Date of Birth:	SSN #:	Phone Number:
Insurance Co. Name:	Id # :	Group # :
Name Of Insured:		Is Patient Covered By Additional Insurance?
Insurance Co. Name:	Id #:	Group #:
Name Of Insured:	Relationship To Patient:	Date Of Birth:

In Case of Emergency: Notify

Name:		Relationship To Patient:
Home Phone #:	Work Phone #:	Cellular Phone #:

Medical History

DATE:	PATIENT NAME:	REASON FOR TODAY'S VISIT:

	GENERAL		GASTROINTESTINAL		EYE, EAR, NOSE, & THROAT
	Chills		Abdominal Pain		Blurred or Double Vision
	Fever		Vomiting		Crossed Eyes
	Difficulty Sleeping		Diarrhea		Earaches
	Dizziness/ Fainting		Constipation		Ear Drainage
	Loss of Appetite		Heartburn		Hearing Loss
	Weight Loss		Hemorrhoids		Ringing in Ears
	Sweats		Rectal Bleeding		Hayfever
	CARDIOVASCULAR		Vomiting Blood		Hoarseness/ Loss Voice
	Chest Pain		Bloating		Sinus Problems
	Irregular Heartbeat		Difficulty Swallowing		**GENITOURINARY**
	High Blood Pressure		**SKIN**		Burning on Urination
	Shortness of Breath With Physical Activity		Hives		Frequent Urination
			Rash		Painful Urination
	Swelling of Ankles		Scars		Loss of Bladder Control
	RESPIRATORY		Moles		**WOMEN ONLY**
	Persistent Cough		Sores that won't heal		Lump on Breast
	Shortness of Breath		Bruising Easily		Abnormal Pap Smear
	NEUROLOGICAL		**MEN ONLY**		Nipple Discharge
	Headaches		Lump on Breast		Vaginal Discharge
	Seizures		Sore on Penis		Hot Flashes
	Head Trauma		Discharge From Penis		Date of Last Menstrual Period
	Epilepsy		Lump on Testicle		Date of Last Pap Smear

LIST CURRENT MEDICATIONS	ARE YOU PREGNANT?
	ALLERGIES:

MARK (X) CONDITIONS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST:

	AIDS		CHICKEN POX		HERNIA		PACEMAKER
	ANEMIA		DIABETES		HERPES		PNEUMONIA
	ARTHRITIS		EMPHYSEMA		HIGH CHOLESTEROL		POLIO
	ASTHMA		GLAUCOMA		HIV POSITIVE		PROSTATE CANCER
	BLEEDING DISORDER		GOITER		KIDNEY DISEASE		SCARLET FEVER
	BRONCHITIS		GONORRHEA		MEASLES		STROKE
	CANCER		GOUT		MIGRAINES		THYROID PROBLEM
	CATARACTS		HEART DISEASE		MISCARRIAGE		TUBERCULOSIS
	CHEMICAL DEPENDENCY		HEPATITIS		MULTIPLE SCLEROSIS		ULCERS

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CONSENT OF TREATMENT

Name of patient :______________________________ **Date of Birth :**________________________

I, the undersigned, hereby consent and grant permission to VICTOR MENDIOLA, M.D. and his employees to perform tests, treatments, and any procedures for myself or the above named minor.

Signature: ______________________________ **Date:** ________________________

If a patient is a minor, relation of person signing: ______________________________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I have insurance coverage; I assign all insurance benefits, if any, payable to VICTOR MENDIOLA, M.D. for services rendered. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow fax transmittals of my medical records, if necessary. I authorize the use of this signature on all insurance submissions.

Signature: ______________________________ **Date:** ________________________

MEDICARE AUTHORIZATION

I, request that payment of authorized Medicare benefits be made either to me or on my behalf to VICTOR MENDIOLA M.D. for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any signature request that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 from, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the coverage determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare Carrier.

Signature: ______________________________ **Date:** ________________________

FINANCIAL RESPONSIBILITY

I understand that payment of charged incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection cost in the event of default of payment of my charges.

Signature: ______________________________ **Date:** ____________________

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ACKNOWLEDGEMENT

Patient Name:____

Date of Birth:____________________

Social Security Number: _______________

I acknowledge that DR. VICTOR O. MENDIOLA, M.D. Provided me with a written copy of his/her notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Signature: _________________________ **Date:** _______________

____________________ ______________

Personal Representative Signature **Relationship to Patient**

Victor Mendiola MD

Patient Declaration of Consent/Decline for contact via SMS Text Messaging

We are constantly working towards improving services to our patients.

As part of this process, we are looking at the possibility of introducing SMS text messaging to our patients' mobile phones with reminders of appointments that have been booked.

This service may also in the future extend to sending other health information by SMS text, such as texts to let patients know that their results are back, or information about special clinics that we are running, such as flu clinics.

The text messages are generated using a secure system. However, they are transmitted over a public network to a personal telephone and as such may not be secure. The practice will not transmit any information that would enable an individual to be identified. The SMS text service for appointment reminders is an additional service and should not be solely relied upon. The responsibility of attending appointments or cancelling them still rests with the patient.

If you would be happy to receive SMS text messages or emails from Hanham Health, please complete the information requested and sign the declaration below.

Please note:

- you must remember to tell us if you change your mobile telephone number, home
- telephone number or email address
- we will not send text messages or emails to anyone under the age of 16 years
- we will not share contact details with any external organization.
- we do not offer a reply facility to enable patients to respond to texts directly
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Patient Name .... Date of Birth ....

Mobile Number ....

Please tick as appropriate:

☐ I consent to Hanham Health contacting me by SMS text message for the purposes of health promotion and appointment reminders
I agree to advise the practice if my mobile number changes, or if this is no longer in my possession
I understand that I can cancel the text message facility at any time by contacting Hanham Health in writing

☐ I decline and do not wish to be contacted by this method

Patient Signature .... Date ....

Victor Mendiola, M.D.

Family Practice

Communication with family and others involved in your care Form

PATIENT IDENTIFICATION
Name: ______________________
Date of Birth______________________
S.S.#______________________
Medical record #______________________

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

NAME:	RELATIONSHIP TO PATIENT:	TYPE OF INFORMATION			
		ALL	Scheduling/ Appointment	Medical	Billing/ Insurance
______________	______________	☐	☐	☐	☐
______________	______________	☐	☐	☐	☐
______________	______________	☐	☐	☐	☐
______________	______________	☐	☐	☐	☐
______________	______________	☐	☐	☐	☐
______________	______________	☐	☐	☐	☐

Specific Instructions or Limitations: ____

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Validation Code: ______________________ Please provide this code to any individual who may be involved in coordinating your care or payment for care. They will be asked for this code before information will be released over the phone.

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify your physician's office if you wish to alter the designations above.

Signature of Patient/ Legal Representative: ______________________ **Date:** ______________

Relationship to Patient: ____

To revoke this authorization, please send a written request with a copy of this form to the address below:

Victor Mendiola, M.D. 7333 North Freeway, ste 250, Houston, Texas 77076

VICTOR MENDIOLA M.D.
FAMILY PRACTICE OFFICE
7333 NORTH FREEWAY
SUITE 250
HOUSTON, TEXAS 77076

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH OPERATIONS.

Patient Name________________________________

I consent to the use or disclosure of my individually identifiable health information as described below.

- I understand that my individually identifiable health information may be used and disclosed to carry out treatment, payment, or health care operations.
- I understand that the Notice of Privacy Policies provides a more complete description of the types of uses and disclosures and that I have the right to review the notice before signing this consent.
- I understand that the terms of the notice may change.
- I understand that I may request that the covered entity restrict how may individually identifiable health information is used or disclosed to carry out treatment, payment, or health care operations. The covered entity is not required to agree to requested restrictions, but if the covered entity agrees to a requested restriction, the restriction is binding on the covered entity.
- I understand that I may revoke the consent at any time by notifying the covered entity in writing, except to the extent the covered entity has taken action in the reliance on the consent.

Signature of patient
Or patient's representative________________________________Date___________

Printed name of Patient
Or patient's representative________________________________Date___________

Relationship to patient________________________________