PATIENT INFORMATION – you must fill out the form completely

PERSONAL INFORMATION

NAME ____________________________________ REFERRING DOCTOR ____________________________

STREET ADDRESS ____ APARTMENT _________

CITY _________________________ STATE _____ ZIP _______ HOME PHONE # _______________________

CELL PHONE OR PAGER # ______________________ DATE OF BIRTH __________ AGE ____ SEX ____

SOCIAL SECURITY # _________________ DRIVER'S LICENSE # ______ MARITAL STATUS: M S W D

EMPLOYER ____ OCCUPATION __________________________

ADDRESS (including city, state, zip) ______________________________ WORK PHONE # __________________

SPOUSE'S INFORMATION

SPOUSE'S NAME __________________________________ EMPLOYER _____________________________

OCCUPATION ____ WORK PHONE # __________________

IN CASE OF EMERGENCY NOTIFY **(OTHER THAN SPOUSE)**

NAME _____________________________ RELATIONSHIP _____________ PHONE # __________________

MEDICAL INFORMATION

FAMILY DOCTOR ______________________ OTHER DOCTORS ___________________________________

ARE YOU CURRENTLY TAKING ANY MEDICATIONS (circle one) Y N If Y, what medications____

DRUG ALLERGIES ____

INSURANCE INFORMATION (found on your insurance card)

PRIMARY INSURANCE CARRIER _____________________ INSURED'S NAME _______________________

INSURED'S DATE OF BIRTH ______________ POLICY # _________________ GROUP # ______________

SECONDARY INSURANCE CARRIER __________________ INSURED'S NAME _______________________

INSURED'S DATE OF BIRTH ______________ POLICY # _________________ GROUP # ______________

INSURANCE ASSIGNMENT

I HEREBY AUTHORIZE IRVIN J. SARON, MD. TO FURNISH ANY MEDICAL INFORMATION TO MY INSURANCE CARRIER. I HEREBY ASSIGN TO IRVIN J. SARON, M.D. ALL INSURANCE BENEFITS PAYABLE FOR SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ANY FEES NOT COVERED BY MY INSURANCE.

SIGNATURE ____ DATE ______________________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

IRVIN J. SARON, M.D., P.A.

11302 Fallbrook, Suite 206
Houston, TX 77065
(281) 890-0911

915 Gessner, Suite 725
Houston, TX 77024
(281) 890-0911

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________

Guardian Name (if applicable): ______________________________

Relationship to Patient (if applicable): ______________________________

Signature of Patient or Guardian: ______________________________

Date: ______________________________

OFFICE USE ONLY

I attempted to obtain the patient's or his/her guardian's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: