FIRST COLONY PRIMARY CARE, P.A.

Sudha N. Chittaluru, M.D

1111 Highway 6 South, Suite 130, Sugar Land, TX 77478

Demographic Information:

Last Name: _____ First Name: _____ M.I: _____

Previous Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

e-mail (please print): _____

Date of Birth: _____ Gender: Male Female

Marital Status: Single Married Divorced Widowed Legally Separated Partner

Social Security Number: _____-_____-_____

Employment Information:

Employer Name: _____

Employment Status: Full-Time Part-Time Self-Employed Retired Not Employed

Emergency Contact Information:

Last Name: _____ First Name:_____

Relation: Spouse Child Parent/Guardian Other

Address: _____

Phone: _____ Guardian: Yes No HIPAA: Yes No

Primary Insurance Information:

Insurance Name: _____ Coverage Beginning Date: _____/_____/_____

Subscriber Number: _____ Co-Pay: _____

Group Number: _____ Group Name: _____

Secondary Insurance Information (if applicable):

Insurance Name: _____ Coverage Beginning Date: _____/_____/_____

Subscriber Number: _____ Co-Pay: _____

Group Number: _____ Group Name: _____

Additional Information (please circle only <u>ONE</u> from each section):

Race: White African American Hispanic American Indian/Alaska Native

Asian Native Hawaiian Other Refuse to Report

Ethnicity: Hispanic or Latino Not Hispanic or Latino Refuse to Report

Language: English Spanish Indian Other

Pharmacy Information:

Name: _____ Phone: _____-_____-_____

Address: _____

How did you hear about us?/Whom may we thank for referring you?

_____

_____

Insurance Authorization and Assignment:

I authorize First Colony Primary Care, P.A. to release any medical and social information acquired during the course of my examination and/or treatment, for the purpose of filing for insurance and other financial coverage, and to provide required information to other medical professionals and facilities for my continuing diagnosis and treatment. I hereby authorize payment of medical benefits directly to First Colony Primary Care, P.A. I understand that I am financially responsible for charges not covered by this assignment of benefits.

Signature: _____

Date: _____/_____/_____

Patient Name: *Date of Birth:*

I.Past Medical History: (*Please circle all medical conditions diagnosed in the past)*

a) Acid Reflux
b) ADD
c) Allergies
d) Angina
e) Anemia
f) Anxiety
g) Asthma
h) Chronic Bronchitis
i) COPD
j) CAD (Coronary Artery Disease)
k) Cancer, type _____
l) Depression
m) Diabetes
n) Hepatitis, type ___
o) Hypertension
p) Heart Attack
q) High Cholesterol
r) Irritable Bowel Syndrome
s) Liver disease
t) Lupus
u) Migraines
v) Osteoporosis
w) Osteoarthritis
x) Rheumatoid arthritis
y) Seizures
z) Thyroid disease

ANY OTHER, Please specify:

II. **Past Surgical History:** Please list all surgeries you have had in the past:

a)_____Date: _____

b)_____Date: _____

c)_____Date: _____

d)_____Date: _____

III. Family History:

(Please place 'X' where applicable in family history)

Condition	**Mother**	**Father**	**Sister**	**Brother**	**Maternal Grandma**	**Maternal Grandpa**	**Paternal Grandma**	**Paternal Grandpa**
Hypertension								
Diabetes Mellitus								
Heart Attack (mention age at first heart attack)								
Cancer, type								
Stroke								
Depression								
Osteoarthritis								
Osteoporosis								
Other (specify)								

Patient Name: *Date of Birth:*

IV. Personal History:

Smoking: Do you smoke? Yes / No

a) If Yes, how many cigarettes per day and for how long? _____
b) If you quit smoking, when did you quit? _____
c) How long did you smoke before quitting and how many cigarettes you used to smoke per day?

Alcohol: Do you consume alcohol? Yes / No

a) If yes, how much and how often: _____
b) If you quit, when did you quit: _____

Exercise/Fitness: Do you exercise? Yes / No

a) If yes, what kind of exercise? _____
b) How many times a week do you exercise? _____

Occupation:

a) What is your occupation?

V. Allergies: Please list allergies to medications and foods including the reaction:

Allergy	Reaction
1.	
2.	
3.	
4.	
5.	

Patient Name: *Date of Birth:*

VI. Current Medications *(please list all medications along with dosage and how often taken)*:

Name of Medication	Dosage	How often taken
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____

VII. Immunizations:

Last Tetanus Booster: _____

Last flu vaccine:_____ other: _____

VIII. Preventive Care:

Last Physical: _____

Last Colonoscopy: _____

Preventive Care (females only):

Last Mammogram: _____

Last Pap smear: _____

IX: For Females only:

Age at first period: Date of Last Menstrual Period:

Are periods regular? Any problems related to menstrual cycles:

Number of pregnancies: Number of live children:

Number of Miscarriages: Number of abortions:

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Acknowledgement of receipt of Notice of Privacy Practices:

Patient Name: _____ Date of Birth: _____

Last Name First Name M.I

I, _____, have received the Notice of Privacy Practices from First Colony Primary Care, P.A.

Signature:_____Date:_____

Patient's Representative, if applicable:

I, _____, a patient representative, state that _____ (name of the patient) has been given the current Notice of Privacy Practices for First Colony Primary Care, P.A.

Patient representative Signature: _____Date: _____

I authorize First Colony Primary Care, P.A. and its staff to discuss my protected health information with the following person(s):

1) Name:_____ Relationship: _____
   Phone No: _____

2) Name:_____ Relationship: _____
   Phone No: _____

3) Name:_____ Relationship: _____
   Phone No: _____

Patient's Signature: _____ Date: _____

FIRST COLONY PRIMARY CARE, P.A.

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1111 Highway 6 South, Suite 130, Sugar Land, TX 77478

Phone: (281) 494-3460 Fax: (281) 494-3463

AUTHORISATION FOR RELEASE OF MEDICAL RECORDS:

Patient Name: _____ Date of Birth: _____

Last Name First Name M.I

Address: _____

City: _____State: _____ Zip Code: _____

Primary Phone No: _____ Alternate Phone No: _____

Medical Records to be released from:

Doctor's name: _____

Doctor's address: _____

Phone no: _____ Fax no: _____

Please fax the following to (281) 494-3463

- Office Visit Notes
- Lab Reports
- Diagnostic Imaging Reports
- Immunization Records
- Consultation reports
- Other _____

By my signature, I authorize release of my medical records to First Colony Primary Care, P.A:

Patient's signature: _____ Date: _____