Please email completed forms to ronald.ralphmdfax@gmail.com

RONALD RALPH, MD
7015 ALMEDA RD
HOUSTON, TX 77054
(713-520-6790 ph (713) 520-0154 fax

NEW PATIENT INFORMATION

Name: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Social Security Number: _____

Gender at Birth: _____

Email address: _____

Referring Doctor: _____

Best way to contact you: _____

RONALD RALPH, MD
7015 ALMEDA RD
HOUSTON, TX 77054
(713-520-6790 ph (713) 520-0154 fax

EMERGENCY CONTACT INFORMATION

Name: _____

Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

EMPLOYMENT INFORMATION

Employer: _____

Occupation: _____

Work Phone: _____

PHARMACY INFORMATION

Name: _____

Address: _____

Phone: _____ Fax: _____

RONALD RALPH, MD
7015 ALMEDA RD
HOUSTON, TX 77054
(713-520-6790 ph (713) 520-0154 fax

MEDICAL RECORD RELEASE FORM

The following individual has requested that all medical records be released to our office.

Name: _____

Date of Birth: _____

Social Security Number: _____

In order for us to fully evaluate the patient's health and make informed decisions, the patient has approved our request for copies of all relevant medical records in your system. Please include all lab reports as well as office notes.

Thank you for expediting this request. Please fax or mail records to office address or fax number listed above.

I hereby authorize the release of all necessary medical records to Dr Ronald Ralph as soon as possible.

Patient Signature: _____ Date: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

RONALD RALPH, MD
7015 ALMEDA RD
HOUSTON, TX 77054
(713-520-6790 ph (713) 520-0154 fax

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our notice of privacy practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature you have reviewed our notice before signing this consent.

The terms of the notice may change. If so, you will be notified at your next visit to update your signature and date.

You have the right to restrict how your protected health information is used and disclosed. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act) allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of information but the practice does not have to agree with those restrictions.
- The patient has the right to revoke the consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email or text you to confirm appointments? ☐YES ☐NO

May we leave a message on your voicemail at home or on your cell? ☐YES ☐NO

May we discuss your medical condition with any member of your family? ☐YES ☐NO

Please list the names of people we may discuss your medical condition with:

_____ _____

_____ _____

_____ _____

Printed Name Signature

_____ _____

Date Witness