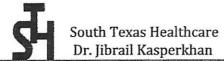
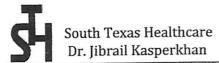
J. San	ıth Texas	Цо	althcara								
Dr.	. Jibrail K			Pat	ient Regi:	stration	MF	RN			
Patient Information	on —										
First Name					Last Nar	ne			MI	Date of Birth	
Address				City				State	Zip		
Please check Prim	ary	Но	me Phone			Work	Phone		Cell Phone		
phone											
Other Name(s) Us	ed					E-mail Address					
Gender	SSN			Pr	referred Language Driver's License						
Marital Status	Preferre	ed C	ontact	Ethn	icity		Race				
Marital Status Married							n				
Primary Care Prov	rider		1 8				Referring Prov	ider			
Responsible Party	(Guaran	tor)			Signal States				Same as p	natient	
First Name	M. Southeries in Control				Last Nar	ne		DE LOS	MI	Date of Birth	
Address					City		***************************************		State	Zip	
Please check Prim Phone	ary	Н	ome Phone			Work Phone Cell Phone					
SSN			Relationship	to Pa	atient Preferred Language Driver's License						
Emergency Conta	ct										
First Name					Last Nar	ne			MI	Date of Birth	
Address					City				State	Zip	
Please check Prim Phone	ary	Н	ome Phone			Work Phone Cell Phone					
I/We do hereby consent to and authorize the performance of all treatments and medical services deemed advisable by the physicians and staff of the South Texas Healthcare to me. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself regardless of insurance coverage. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize South Texas Healthcare to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.											
Signature of I	Patient/R	esp	onsible Party				Date				
Name of Patie	ent/Resp	ons	ible Party (Ple	ease P	rint)		Relationship	p to P	atient		



Patient Registration

Pharmacy Information							
Preferred Pharmacy		Secondary Pharmacy					
Name		Name					
Address		Addr	ess				
Phone		Phon	е				
Fax		Fax					
Advanced Directives							
	rable Power of Date Revie		ney 🔲 Living Will 🔲 HC Proxy				
Medications – List all medications you ta	ike prescriptio	n and	non-prescription, and the dosage				
	I do not take		The second of th				
	1 tuo not take	any m					
Medication Name			Dosage				
A CONTRACTOR OF THE CONTRACTOR							

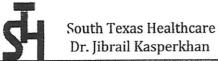
Medication and Food Allergies – List all	known allergie	s (drug	gs, food, animals, etc.)				
	☐ No Know	wn Alle	ergies				
Medical History - Check if you have ever	r experienced t	he follo	owing conditions, and year of onse	t.			
Condition	Year		Condition	Year			
None		G	ıllbladder Disease				
Allergies		G	ERD (Reflux)				
Anemia		Пн	epatitis C				
Angina			yperlipidemia				
Anxiety			ypertension				
Arthritis			ritable Bowel Disease				
Asthma		Li	ver Disease				
Atrial Fibrillation			igraine Headaches				
Benign Prostatic Hypertrophy			yocardial Infarction				
☐ Blood Clots			steoarthritis				
Cancer – Type			steoporosis				
Cerebrovascular Accident			eptic Ulcer Disease				
Coronary Artery Disease			enal Disease				
COPD (Emphysema)			rizure Disorder				
Crohn's Disease	5		nyroid Disease				
Depression			her				
Diabetes			her				



Patient	Registration
rauciii	Registration

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Surgical History - Check if you have rece	ived	the fo	llov	zin g	gpr	ocec	ures,	and year	perforn	red.		
Surgical Procedure		Year					Surgic	al Proced	lures			Year
None					Male Only							
Angioplasty				Prostate Biopsy								
Angioplasty w/Stent				TURP (Trans-urethral resection of Prostate)								
Appendectomy				[]	rar	ıs-uı						
Arthroscopy Knee				L			tomy					
Back Surgery				L		ther						
CABG (heart bypass)				L] 0	ther						
Carpal Tunnel Release				_								
Cataract Extraction				<u>_</u>				male On				
Cholecystectomy				닏				on Mamn		<i>-</i>		
Colectomy				阜				bal Ligati	ion			
Colostomy				Ļ			t Biop					
☐ Gastric Bypass				Ļ			ean Se	ection				
Hernia Repair				부	=	and						
Hip Replacement				 -			rector				_	
☐ Knee Replacement				1			ctomy					
LASIK				+			necton		1			
Liver Biopsy				1-				Mammop.	lasty		_	
Pacemaker				+			BSO	terecton			_	
Small Bowel Resection				1-			-					
Thyroidectomy				Other								
☐ Tonsillectomy	CONTRACTOR OF THE PARTY OF THE					ther						
Health Maintenance – Check if you have	rece		ne i	Ollic	WII	ng, a	na aau		in (Cacitie	exam.		Data
Exam		Date		+	7.0	XZAL 1	-	Exam			+-	Date
None				 -			Exam					
Breast Exam	☐ Influenza Vaccine											
Cardiac Stress Test	Lipid Panel Mammogram									-		
Colonoscopy	PAP Test											
DEXA Scan												
Echocardiogram	Physical Exam Pneumococcal Vaccine								_			
EKG									+-			
Eye Exam	Pulmonary Function Test							+-				
FOBT (stool card for hidden blood)	Sigmoidoscopy											
Foot Exam	mber(s) has had any of the following conditions.											
	salate	I(S) He	IS III	au e	any	OI U	ite itoiit	owing co.	Helidines			
Adopted	3.6	43	г	- 4-1-		D		Ciaton	Othe		Other	Other
Diagnosis	IVIC	other	Fa	athe	er	Bro	other	Sister	Ulle	1		Other
Alcoholism	_	\dashv		믐			=	⊢⊢	+ 片		\dashv	$\vdash \vdash \vdash$
Allergies	-	H		님			=-	$\vdash \vdash \vdash$	+ $+$	_	\dashv	
Alzheimer's Disease	-	ㅡ	_	님			\dashv	$\vdash \vdash$	$+$ \dashv		+	$\vdash \vdash \vdash$
Asthma Placed Disease		H-	_	H			+-		+ $+$	_	十	+
Blood Disease		 	_	님			+-	H	$+$ \dashv		H	+ + -
CAD (Heart Attack)		${\dashv}$		님			\dashv	H	+ +	-	+	+ + -
Cancer - Type:		\dashv	_	뉘			+	H	+ $+$	_	\dashv	+H
CVA (Stroke)	-	H		뉘			-	 	+ + +		+	+
Depression Developmental Delay	-	러	-	H		-	\dashv	- -	+	_	一一	+ +
Diabetes	-	Ħ	<u> </u>	님			\exists		1 1	_	一一	+H
Diabetes	1		1									



Patient Registration

MRN			

Family History - co	ntinued									
Diag		Mother	Father	Brothe	er Sister	Other	Other	Other		
Eczema										
Hearing Deficiency										
Hyperlipidemia (Hi	gh Cholesterol)									
Hypertension (High	Blood Pressure)						Ш			
Irritable Bowel Dise	ease									
Learning Disability										
Mental Illness										
Tuberculosis										
Obesity										
Osteoarthritis										
Osteoporosis										
PVD										
Renal Disease										
Other										
Other										
Social History for A	dult Patient									
Occupation			Em	ployer						
•										
Do you have childre	en? Yes No	How ma	ny?	I	Female(s) Male(s)					
Tobacco Use	☐ Daily ☐ V	leekly Less			Chewing Pipe					
	П г /// / / / / / / / / / / / / / /	24			Cigar Cigarette					
□No	Former/Year qu	IC:		[Smokeless Brand:					
Alcohol Use	☐ Daily ☐ V	Veekly	Less	-	Пр	□ Wino				
		•			Beer Wine Liquor Other:					
☐ No	☐ Former/Year qu	it:		1	Liquor Other:					
	☐ Moderate ☐ V	'igorous	Seder	itary S	Sleep Pattern	:				
Exercise Activity	Davis (Maalr			I	☐ Changes ☐ No Changes					
	Days/Week:									
Caffeine Use	☐ Daily ☐ V	Veekly	Less] [Chocolate		ee			
		• >=			Soda Soda	Tea				
□No	Former/Year qu	it:		1	☐ Tablets	Oth	er:			
							10.00			