3233 Woodward Drive
Huntsville, TX 77340
Phone: 936-439-5213
Fax: 936-439-5216

Path to Cure NORTH HOUSTON CANCER CLINICS
Elham Abbasi, MD
Certified

3115 College Park Drive
Suite #108
The Woodlands, TX 77384
Phone: 936-439-5213
Fax: 936-439-5216

Patient Name: ___________________________ **Date of Birth:** ______________ **Age**_________**M** ☐ **F** ☐ **Date:** _________

Social Security last 4 #: _______ **Religion:** ___________________________ **email address:** _________________

Mailing Address: ______________________________________ **City/State:** ______________________________ **Zip:** __________

Home Phone: ( ) ________________ **Employer:** ____________________________ **Work Phone:** ( ) ________________

Emergency Contact: ____ **Phone:** ( ) ________________

Family Doctor: ______________________________________ **Who referred you to us?:** ____________________________________

Please list individuals we are authorized to speak with regarding your care/account: (Include the last four digits of their social security number *or* their mother's maiden name for verification purposes. Thank you.)

Name: ____ **Last Four Digits of SS# or Mother's M.N.:** __________________________

Name: ____ **Last Four Digits of SS# or Mother's M.N.:** __________________________

Name: ____ **Last Four Digits of SS# or Mother's M.N.:** __________________________

SPOUSE / PARENT / GUARDIAN / RESPONSIBLE PARTY:

Name: ____ **Date of Birth:** _________________________ **(REQUIRED)** **M** ☐ **F** ☐

Social Security #: _________________________ **Address:** ____

City/State: ____ **Zip:** ______________ **Home Phone:** ( ) ________________

Employer: _____________________________________ **Address:** ____

City/State: ____ **Zip:** _______________ **Work Phone:** ( ) ________________

INSURANCE INFORMATION (Primary) (PLEASE PROVIDE INSURANCE CARD FOR US TO COPY.)

Insurance Co.: ____ **Address:** ____

City/State: ______________________________________ **Zip:** _____________ **Insurance Co. Phone:** ( ) ________________

Policy Holder: ____ **Date of Birth:** _________________

ID/Policy #: _______________________ **Group #:** _______________________ **Group Name:** ______________________________

INSURANCE INFORMATION (Secondary)

Insurance Co.: ____ **Address:** ____

City/State: ______________________________________ **Zip:** _____________ **Insurance Co. Phone:** ( ) ________________

Policy Holder: ____ **Date of Birth:** _________________

ID/Policy #: _______________________ **Group #:** _______________________ **Group Name:** ______________________________

To the best of my knowledge, all of the above information is true and complete. I understand that I am responsible to pay for all services rendered to me, and that I am willing to make specific arrangements to pay whatever part is not covered by insurance on a timely basis. (**PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR, AND IS NOT A SUBSTITUTE FOR PAYMENT**.) **IN ORDER TO MONITOR YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.** Thank you.

If this account is assigned to an attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. I hereby assign all medical benefits to which I am entitled to my physician for services rendered to my dependent or me. This assignment will remain in effect until revoked, by me, in writing. A photocopy of this assignment is to be considered as valid as the original.

PATIENT SIGNATURE: ____ **DATE**: ______________________________

MEDICARE ASSIGNMENT/SIGNATURE ON FILE:

I request that payment of authorized Medicare benefits be made either to me, or on my behalf to North Houston Cancer Clinic for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to the Centers for Medicare and Medicaid Services, formerly the Health Care Administration, and its agents, any information needed to determine these benefits, or the benefits payable for related services.

SIGNATURE: ____ **DATE**: ________________________________

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MEDICAL & SURGICAL HISTORY

Patient Name:______________________ **Date of Birth: _________________**

Medical Condition History

____
____
____
____
____
____
____
____
____
____
____

Surgery

____
____
____
____

Please list the names of Hospitals and Clinics where you have had MRI/CT/XRAYS

____
____
____
____

Preventive Health Maintenance

Last Mammogram: ____________________________
Last Colonoscopy: ____________________________

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Medication and Allergy List

Date: ________________

Patient Name: _________________________________ **DOB:** _______________

Please list all prescriptions, vitamins, herbs, and over-the-counter medications that you are currently taking and /or bring your medications with you to your appt.

Medication **Strength** **Dose** **How many times a day**

____
____
____
____
____
____
____
____
____
____
____
____

Allergies

Medication **Describe Reaction**

____
____
____
____

Have you ever had an allergic reaction to: Contrast Dye Iodine Shell Fish

What type of reaction did you have: Hives Shortness of breath?

Additional Comments and / or Information:

____
____
____

Pharmacy Name ____________________________ **Phone #** __________________

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SOCIAL & FAMILY HISTORY

Patient Name:______________________ Date of Birth:___________ Age: _____

Do you use any of the following? (Please check all that apply)

Alcohol:______ How much?______ How often?_______ If quit, how long?______
Type: Beer , Liquor , wine , social drinker

Tobacco:_____ How much?______ How often?_______ If quit, how long?______
Type : Cigarette , electronic cigarettes, Cigars, chewing Tabaco, snuff, pipe

Recreational Drugs: How much? ____How often?_______ If quit, how long?______
Type :amphetamines, cocaine, crack cocaine, downers, Heroine, Marijuana, other

---

Is there are any family history of Cancer/ Blood Disorders? Such as
Colon cancer, Breast cancer, throat cancer, lung cancer, leukemia, lymphoma ,…
age at diagnosis if known,

Mother: ______
Father: _______

Brothers: _______
If more than one please add
Sisters: _______
If more than one please add

Grandmother (M) _______
Grandmother (F) _______

Grandfather (M) _______
Grandmother (F) _______

Aunts: _______
If more than one please add

Uncles: _______
If more than one please add