Carson T. Lo M.D.
Linda S. Yancey, M.D.

West Houston Infectious Disease Associates
NEW PATIENT INFORMATION

Thank you for choosing West Houston Infectious Disease Associates. Please completely fill out this form to ensure that we can help you better.

Patient Name: _____ Date of Birth: _____

Address:_____
Number Street Apt. No. City State Zip

Home Phone: _____ Cell: _____ Work: _____

Email: _____ (Requested, used for patient portal)

Gender: M F Marital Status: S M W D Social Security #: _____

Race: _____

Emergency Contact: _____
Name Phone Relation

Primary Care Physician: _____ PCP Phone: _____

Referring Physician: _____ Referring Physician Phone: _____

Pharmacy: _____ Pharmacy Phone: _____

Occupation: _____ Employer Name: _____

Employer Address: _____
Number Street City State Zip

Employer Contact No.: _____

Responsible Party: (**Complete this section only if someone other than the patient is financially responsible**)

Name: _____ DOB: _____ Social Security #: _____

Address: _____
Number Street City State Zip

Home Phone: _____ Work: _____

Primary Insurance Company: _____ Phone: _____

Insured's ID #: _____ Group #: _____

Insurance Address: _____
Number Street City State Zip

Insured's Name: _____ Insured's Date of Birth: _____

Insured's Employers: _____ Insured's Social Security #:_____

Secondary Insurance Company: _____ Phone: _____

Insured's ID #: _____ Group #: _____

Insurance Address: _____
Number Street City State Zip

Insured's Name: _____ Insured's Date of Birth: _____

Insured's Employers: _____ Insured's Social Security #:_____

CARSON T. LO, MD, PA PATIENT'S MEDICAL HISTORY

Name: _____ Date:_____

Chief Complaint (Reason for Visit/ What are you coming in for?):_____

Allergies: _____

Surgery:

Reason	Date	Reason	Date

LIST ALL MEDICATIONS YOU ARE NOW TAKING
(Include over-the-counter medications)

DRUG NAME	DOSAGE	FREQUENCY

VACCINE/DATE	TEST/EXAM/DATE
Tetanus/TD-	Rectal/Stool-
Influenza (flu)-	Cholesterol-
Pneumonia-	Eye-
Hepatitis-	Dental-
Tuberculosis Testing-	

Medical History (Have you been diagnosed with any of the following?):

Allergies/hay fever	Y	N	Endocrine disease	Y	N	Memory failure	Y	N
Anemia	Y	N	Epilepsy/Seizures	Y	N	Menstrual dysfunction	Y	N
Anxiety/Depression	Y	N	GI Disorder	Y	N	Migraine	Y	N
Arthritis	Y	N	Gout	Y	N	Osteoporosis	Y	N
Asthma	Y	N	Hearing loss	Y	N	Pneumonia	Y	N
Congenital heart disease	Y	N	Heart murmur	Y	N	Rheumatic fever	Y	N
Congestive heart failure	Y	N	Hemorrhoids	Y	N	Sexual dysfunction	Y	N
COPD	Y	N	Hyperlipidemia	Y	N	STDs	Y	N
Coronary Disease	Y	N	Hypertension	Y	N	Stroke	Y	N
Diabetes	Y	N	Incontinence	Y	N	Thyroid Disease	Y	N
Drug Addiction	Y	N	Liver disease	Y	N	Other (please specify): _____	Y	N

Women Only: Pregnant? Yes No Planning pregnancy? Yes No

Family History (who in your family has/had any of the following – encircle the condition that applies and specify family member afflicted)

1) Epilepsy	6) Hay fever	11) Arthritis	16) Hepatitis	
2) Migraine	7) Asthma	12) Heart disease	17) Cancer	
3) Glaucoma	8) Anemia	13) Stroke	18) Depression	
4) Diabetes	9) Bleeding disorder	14) Hypertension	19) Alcoholism	
5) Thyroid disease	10) Osteoporosis	15) Lipid disorder	20) Mental Illness	

Habits:

Smoke
Current Former Never
Packs daily:_____
How long?_____
Quit
Date:_____

Coffee: Cups daily:_____
Other_____

Alcohol: Type _____
Amount_____

Exercise routine: _____

Sleep: ___ Difficulty falling asleep
___ Continuous disturbances
___ Snoring
___ Early morning awakening
___ Daytime drowsiness

Other:_____

CARSON T. LO, M.D., P.A.

Review of Symptoms

Do you now have or have you had any problems related to the following symptoms? Circle Yes or No. Please explain any. "Yes" answer in the space provided.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Night Sweats	Y	N
Fatigue Headache	Y	N

Other _____

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N

Other _____

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N

Other _____

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Weakness	Y	N
Numbness/tingling	Y	N

Other _____

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Weight Loss	Y	N
Weight Gain	Y	N
Tired/Sluggish	Y	N

Other _____

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Diarrhea	Y	N
Constipation	Y	N
Indigestion/heartburn	Y	N

Other _____

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N

Other:_____

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N

Other:_____

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N

Other:_____

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary Frequency	Y	N
Blood in urine	Y	N
Vaginal/urethral discharge	Y	N

Other:_____

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Loss of breath	Y	N

Other:_____

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem or bleeding	Y	N

Other _____

Psychological

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N

Other:_____

PATIENT NAME: _____

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have received the Notice of Privacy Practices of WEST HOUSTON INFECTIOUS DISEASE ASSOCIATES (WHIDA)which explains how my medical information will be used and disclosed. I understand I am entitled to receive a copy of this document.

_____ _____

Signature of Patient /Authorized Representative **Date**

AGREEMENT AND CONSENT FOR SERVICES

CONSENT FOR SERVICES:
I request, authorize, and give consent to West Houston Infectious Disease Associates to provide me with medical office services and/or products. I understand that any services and/or products to be provided by West Houston Infectious Disease Associates will be requested by my physician and will be provided under his supervision. I understand that I have the right to select a pharmacy of my choice.

CONSENT FOR RELEASE OF MEDICAL INFORMATION:
I hereby authorize and give my consent to my physicians, hospitals, and/or any holder of medical or other information about myself, to release any and all said information to West Houston Infectious Disease Associates and its agents, employees, and representatives.

CONSENT FOR RELEASE OF MEDICAL RECORDS TO INSURANCE CARRIER:
I hereby authorize West Houston Infectious Disease Associates to furnish to my insurance carrier(s) or its agent(s) any information concerning my illness and/or treatment and agree to hold them harmless from any and all liability from same.

CONSENT FOR RELEASE AND USE OF MEDICAL INFORMATION:
I hereby authorize and give my unconditional consent to West Houston Infectious Disease Associates, its employees, and agents to release medical and other information about myself to any local, state, or federal health care regulatory bodies, private healthcare accrediting organizations with which West Houston Infectious Disease Associates is affiliated or seeks affiliation or to representatives of West Houston Infectious Disease Associates' Continuous Quality Improvement Committee.

WEST HOUSTON INFECTIOUS DISEASE ASSOCIATES
FINANCIAL POLICY

WE at West Houston Infectious Disease Associates are committed to providing you with quality care and we are pleased to discuss our professional fees with you should you have any questions. Your clear understanding of our financial policy is important to our professional relationship.

TO assist us in establishing your WHIDA financial account, please:

- Supply all necessary information for the accurate billing of claim, including your insurance card, employer information and demographic information.
- Satisfy all insurance co-payments, deductibles, co-insurances, and non-covered services at the time services are rendered.
- Provide your insurance company and WHIDA with any additional information requested to complete the processing of claims filed on your behalf.
- Authorize release of information necessary for insurance filing and pre-certification They areresponsible for providing current insurance information for self. Please note that co-payments deductibles, and/or co-insurances are expected at the time of service.

REGARDING INSURANCE
Your insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, non-covered charges, co-insurance, and secondary insurance,

PATIENT NAME: _____

coordination of benefits, pre-existing conditions, or “reasonable and customary” charges other than to supply the factual information as necessary. You are responsible for timely and complete payment of your account.

CONTRACTED MANAGED CARE PLANS (HMO, PPO, EPO):
Each time you make an appointment with our physician, it is your responsibility to make sure he/she is currently under contract with your managed care plan. Verification of your coverage and benefits may be required. Often this verification requires us to share the reason for your visit with your managed care plan. **Please plan to show your current card at each visit.**

If you are referred to a specialist or decide you need a specialist, you may be required by your managed care plan to call your Primary Care Physician in order to obtain an insurance referral. It is your responsibility to keep track of the expiration dates and for giving your doctor’s office a minimum of 24-hour notice before being seen by a Specialist.

- I have read and I understand that I am personally responsible for payment on this account.
- Assignment: I hereby authorize payment directly to WHIDA or my Physician. Any changes in this authorization must be received in writing within 30 days of the effective date.
- In the event my insurance company deems a service to be “non-covered”, I understand that I am personally responsible for payment.
- I am responsible for the payment of bank penalty fees, plus the original amount owed should any check I issue to WHIDA or my Physician be returned.
- I agree to the release of any and all medical information (including HIV test results and financial information necessary to process this and any future claims) to my insurer or payer of health benefits, as I may designate that or another entity from time to time, for an indefinite period or until I submit a written revocation of this release. Any changes to this authorization must be received in writing within thirty days of effective date.
- Failure to comply with any of the above policies may lead to dismissal from this practice.
- I understand that non-payment of fees that are my responsibility entitles WHIDA to send my account to a collection agency.
- I understand that if I do not assign benefits, I will be responsible for the amount in full at the time the services are rendered.

Missed appointments:
I understand that when I schedule an appointment with WHIDA, this office reserves the slot exclusively for me. If I do not give at least 24 hours’ notice, the office may miss an opportunity to help another patient who needs an appointment.

- NOTICE: It is the patient’s responsibility to call our office at least 24 hours in advance of his/her scheduled appointment about any cancellations or rescheduling. Without such notice, a “NO SHOW” fee will be charged to the patient.

_____ _____
Signature of Patient/Authorized Representative Date

_____ _____
Print Name DOB