PATIENT INFORMATION

(PLEASE PRINT)

DATE: _____

NAME: _____
(LAST) (FIRST) (MI)

ADDRESS: _____

_____
(CITY) (STATE) (ZIP CODE)

HOME PHONE #: _____ CELLULAR PHONE # _____

WORK PHONE #: _____ **EMAIL ADDRESS**: _____

DATE OF BIRTH: _____ GENDER M F (CIRCLE ONE)

SOCIAL SECURITY #: _____

OCCUPATION: _____ RETIRED ? YES NO

EMPLOYER ADDRESS: _____

NAME OF SPOUSE/PARENT: _____ CELLULAR PHONE # _____

NAME OF NEAREST RELATIVE TO CONTACT IN CASE OF EMERGENCY: (NOT LIVING WITH YOU)

NAME: _____ RELATIONSHIP:_____

HOME PHONE #: _____ WORK / CELL # :_____

REFERRED BY: _____ PRIMARY CARE PROVIDER: _____

Primary spoken language: English Spanish Other: _____
(Circle one)

Race: American Indian or Alaskan Native / Asian / Black or African American / Native Hawaiian or other Pacific Islander / White Other: _____

Ethnicity: Hispanic / Latino Arab / American

Marital Status: Married Single Divorced Widowed Separated Never Married

Smoker Status: Never Previous Current Height; _____

When did you stop smoking? _____ Weight: _____

How many years did you smoke? _____ Waist: _____

Office:
1705 East 29th Street
Bryan, TX 77802

Telephone: (979) 775-9483
Fax: (979) 775-9557
Answering Service: (979) 361-5063

Solo private practice
of Nephrology since
July 11, 1977

PATIENT HEALTH INFORMATION
(PLEASE PRINT)

DATE: _____

NAME: _____
(LAST) (FIRST) (MI)

PAST MEDICAL AND SURGICAL HISTORY:

Medical problems / illnesses:	Surgeries:	Year or age	Surgeon AND Hospital
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list ALL your Physician Names and ADDRESSES:

Physician Name: _____ Address: _____ City/State: _____ Telephone #: _____ Fax #: _____	Physician Name: _____ Address: _____ City/State: _____ Telephone #: _____ Fax #: _____	Physician Name: _____ Address: _____ City/State: _____ Telephone #: _____ Fax #: _____
Physician Name: _____ Address: _____ City/State: _____ Telephone #: _____ Fax #: _____	Physician Name: _____ Address: _____ City/State: _____ Telephone #: _____ Fax #: _____	Physician Name: _____ Address: _____ City/State: _____ Telephone #: _____ Fax #: _____

ALLERGIES to Foods and MEDICATIONS: ☐ **No Known Medications Allergies**

1. Allergy: _____ Reaction _____ 2. Allergy: _____ Reaction: _____
3. Allergy: _____ Reaction _____ 4. Allergy: _____ Reaction: _____
5. Allergy: _____ Reaction _____ 6. Allergy: _____ Reaction: _____

PHARMACY: please include local and / or mail order names and address / phone # (please provide RX card for copies)

Pharmacy: _____ **Mail Order:** _____
Address: _____ Address: _____
City / Zip Code: _____ City / Zip Code: _____
ID # _____
Pharmacy plan / Formulary: Medicare D BCBS UHC Medicaid Aetna OTHER: _____

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