SUGAR LAKES FAMILY PRACTICE
PATIENT INFORMATION
ADULT

Date ____________________ Dr. ____________________

Name (Last) ________________ (First) ____________________ (MI) ________

Address ____

City ________________________________ State ___________ Zip ___________

Home __________________ Cell __________________ Work __________________

SSN ___________________________ Date of Birth ___________________________

Email ____

Employer ____

Marital Status ____________________ Spouse Name ________________________

Emergency Contact _______________________ Phone _______________________

Relationship to Emergency Contact ____

PHARMACY INFORMATION

Local Pharmacy ______________________ Phone ____________________________

Mail Order Pharmacy ____

Phone __________________________ Fax _________________________________

Address ____

INSURANCE INFORMATION

Insurance Name ____

Insurance ID ____________________________ Group ______________________

Insured Name _________________________________ DOB ___________________

Insured Employer ____

I hereby authorize direct payment of medical benefits to Sugar Lakes Family Practice for services rendered. I understand that I am financially responsible for any balance not covered by my insurance company. I also authorize a release of my medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I certify that the information given by me in applying for payment is correct. I authorize release or reports on request. I request that payment of authorized benefit be made on my behalf. A photocopy of the assignments shall be valid as original.

Patient Signature ______________________________________ Date ___________

Sugar Lakes Family Practice Patient History

Name: ______________________________ Date Of Birth: ___________________________
Occupation: __________________________ Sex (circle one): Female Male
Education :(check all) Elementary_____ High School____ College______ Post Grad_______
Religion: ____________________________ Marital Status: S____ M_____ D_____W___
Last (if applicable) Colonoscopy _______________ Last Mammo____________________
Last Bone Density ______________________ Last Dental Exam ___________________________

Current Medications: ____________________ Allergies: ______________________________
____ ______________________________________
____ ______________________________________
____ Surgeries: ______________________________
____ ______________________________________
____ ______________________________________

Medical Problems ________________________ Family Medical Problems: __________________
____ ______________________________________
____ Father: ________________________________
____ Mother: ________________________________
____ Brother: ________________________________
____ Sister: _________________________________
____ Children: _______________________________

Any Cancer in Family Y N If yes, Type / In whom: ________________________________
Any Psychiatric Diagnoses in Family Y N If yes, Type/In whom: ____________________

Do you use:
Tobacco or Smoke? _______ Amount Daily? ___________ How many years? ___________
Alcohol? _______________ Quantity per week? _____________
Nutritional Supplements?______ Type _____________________________________
Recreational Drugs? __________ Type _____________________________________
Have you had a recent (give year) DT ________ Flu Vac _________ Pneumonia Vac _________
Females: LMP _______________ Number of Pregnancies: ___________ Miscarriages: ________
Do you have an Advance Directive: Y______ N________

Circle all that Apply

Anemia	Anxiety	Arthritis	Asthma
Allergies	Cataracts	Chest Pains	Dizziness
Glaucoma	Headaches	Hemorrhoids	High Blood Pressure
Leg or Foot Pain	Loss of Urine/Feces	Night Sweats	Nose Bleeds
Positive TB skin Test	Shortness of Breath	Sinus Trouble	Skin Disease
Stomach Problems	Stool or Bowel	Thyroid Problems	Weight Loss or Gain

John R. Vanderzyl, M.D
John R. Pozzi, M.D
Henry A. Mata JR., M.D
Jennifer Falkner PA C

Nora L. Cantu, M.D
J. Mark Trippett.M.D
Anne Marie Ponce DeLeon, M.D
Ann M. Hekkinen, M.D

Access your records Via Internet/App

_**Yes**, I would like to sign up __**No**, I do not want to sign up

Phone App-Download Healow with your app store.

Authorization for Web Portal

Sugar Lakes Family Practice offers a web portal for patients to communicate with the office and to obtain lab results via web. This authorization form is to authorize Sugar Lakes Family Practice to post **normal** lab results to the patient portal without receiving results via telephone from the nurse. If you choose to opt out, your lab results will not be posted to the web portal until you have discussed these results with a nurse. If you choose to opt in, your **normal** lab results will be posted to the web portal once the Doctor has reviewed the results. If you have not received a call from a nurse or a notice via email stating labs have been posted to the web portal within 10 days, please contact our office regarding results.

— **Yes-** I would like to have my **normal** lab results posted to the web portal without talking to a nurse.

— **No-** I would like to receive a phone call from the nurse prior to my normal results being posted to the web portal.

Signature: ____.
(Patient or Guardian)

Print Name:________________________________. **Date:**__________.

Email:____________________________________

JOHN R. VANDERZYL, M.D.
JOHN R. POZZI, M.D.
HENRY A. MATA JR., M.D.
NORA L. CANTU, M.D.

J. MARK TRIPPETT, M.D.
ANNE MARIE PONCE DE LEON, M.D.
ANN M. HEIKKINEN, M.D.
JENNIFER FALKNER, P.A.C.
BENITA BROWN, P.A.C.

Sugar Lakes Family Practice
Controlled Substance Prescription Consent and Agreement

The following is an agreement between the patient and healthcare providers of this practice to establish clear guidelines for the prescription and use of controlled substances. This includes medications prescribed to treat conditions such as pain, anxiety, sleep disturbance and attention deficit disorder. This is to help ensure the safety of the patient and compliance with the law regarding these medications.

I will
* fully and accurately communicate to my provider the character and intensity of my symptoms, the effect these symptoms have on my daily life and how well the medicine helps to relieve the symptoms.
* safeguard my medications from loss or theft and understand lost or stolen medications will not be replaced.
* request controlled substances (including refills) only at office visits or during regular business hours, no prescriptions will be provided during evenings and/or weekends

I will not
* share my prescriptions with any other individuals
* attempt to obtain new prescriptions or refills for controlled substances from other healthcare providers without informing my prescribing provider at this practice
* use my prescribed controlled substances along with alcohol, sleep medications or other substances/medications that may cause drowsiness
* increase my dose and/or frequency without my provider's permission under any circumstances
* call for refills earlier than they are due

I understand
* that controlled substances have potential side effects including addiction, liver/kidney damage, allergic reactions, drowsiness and mental impairment.
* that if there is no evidence of improvement in symptoms (pain, anxiety) and/or my quality of life with use of the prescribed medications, they may be discontinued
* if I am referred to another healthcare provider or treatment (i.e. specialist, pain management, physical therapy, counseling) and I fail to follow through with this recommendation, my medication may be discontinued
* I will be required to follow up with my provider regularly and no less than every 6 months
* medications will not be refilled early due to travel, patient using medication at higher dose/frequency than prescribed (unless previous consent given by prescriber)

I consent to
* my provider reviewing my medical records from other treating healthcare providers or pharmacies
* random drug testing and/or random pill counts from the healthcare provider

By signing below, I agree that I understand the terms of this contract and will ask for clarification of any issues that I do not understand. I consent to treatment of my condition(s) with controlled substances. I understand that my failure to abide by the terms of this agreement may result in the discontinuation of prescribed controlled substances and termination of the doctor-patient relationship.

______________________________ Patient or Patient's Guardian

______________________________ Date

Sugar Lakes Family Practice

16902 Southwest Freeway Suite 100
Sugar Land, TX 77479
281-565-2800 Fax 281-565-2801

Acknowledge of Receipt of Notice of Privacy Practices
Sugar Lakes Family Practice reserves the right to modify privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for Sugar Lakes Family Practice.

____
Name of Patient (Print)

____
Signature of Patient or Guardian

____
Date

For medical results contact:

Work______________________

Cell______________________

Fax______________________

Results can be given to:

Spouse (name) ______________________

Other (name) ______________________

MEMORIAL HERMANN INFORMATION EXCHANGE "MHiE"
PATIENT CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose: The MHiE is a health information exchange network developed by Memorial Hermann Healthcare System. Exchange Members include hospitals, physicians and other healthcare providers. Exchange Members are able to share electronically medical and other individually identifiable health information about patients for treatment, payment and healthcare operation purposes. We are an Exchange Member of the MHiE and we seek your permission to share your health information with other Exchange Members via the MHiE. By executing this form, you consent to our use and electronic disclosure of your health information to other MHiE Exchange Members for treatment, payment and healthcare operation purposes. We will not deny you treatment or care if you decline to sign this Consent, but we will not be able to electronically share your health information with your healthcare providers that participate in the MHiE as Exchange Members if you do not sign this Consent.

Instructions: If you agree to allow us to disclose your health information with other MHiE Exchange Members please complete the relevant portions of and sign this Consent.

Patient Name (Last, First, Middle)	Date of Birth

Information that will be Disclosed; Purpose of the Consent for Disclosure

I, ________________________ [Patient Name], hereby consent to the disclosure of my medical, health and encounter information by any and all Memorial Hermann Healthcare System providers (collectively the "Provider") to other participating providers in the MHiE (Exchange Members) who may request such information for treatment, payment or healthcare operation purposes. I understand the information to be disclosed includes medical and billing records used to make decisions about me.

I HEREBY SPECIFICALLY AUTHORIZE PROVIDER TO RELEASE ALL TYPES AND CATEGORIES OF PROTECTED HEALTH INFORMATION TO OTHER HEALTHCARE PROVIDERS THAT PARTICIPATE IN THE MHiE FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATION PURPOSES, [INCLUDING BUT NOT LIMITED TO, YOUR ALCOHOL AND TREATMENT RECORDS, YOUR DRUG ABUSE TREATMENT RECORDS, YOUR MENTAL HEALTH RECORDS, AND YOUR HIV/ACQUIRED IMMUNE DEFICIENCY SYNDROME RECORDS, AS APPLICABLE].

No Conditions: This Consent is voluntary. We will not condition your treatment on receiving this Consent. **HOWEVER, IF YOU DO NOT SIGN [AND INITIAL] THIS CONSENT, WHERE REQUIRED, YOU CANNOT PARTICIPATE IN THE MHIE.**

Effect of Granting this Consent: This Consent permits all MHiE Exchange Members to access your health information. Exchange Members of the MHiE are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Term and Revocation

This Consent will remain in effect until you revoke it. You may revoke this Consent at any time by completing the MHiE notice of revocation. The MHiE notice of revocation is available by calling 713-456-MHiE (6443). Revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your notice of revocation. Revocation of this Consent will also have no effect on your personal health information made available to Exchange Members during the timeframe in which your Consent was active.

INDIVIDUAL'S SIGNATURE

I have had full opportunity to read and consider the contents of this Consent. I understand that, by signing this Consent, I am confirming my consent and authorization of the use and/or disclosure of my personal health information, as described herein.

Signature: ______________________ Date: ______________

If this Consent is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: ______________________

Relationship to Individual: ______________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include this Consent in the individual's records.

Official Use Only:

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