

LUCIAN J. RIVELA, M.D., F.A.C.S.
PATIENT INFORMATION

NAME: _____

DOB: _____ AGE: _____ SS#: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

CELLULAR/PAGER: _____ MARITAL STATUS: M D S W SEP

REASON FOR VISIT: _____

REFERRED BY: Newspaper Magazine Ad Phone Book Previous Patient
 Internet Physician Other

PLEASE LIST REFERRAL NAME/LOCATION: _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

PATIENT'S EMPLOYER INFORMATION

EMPLOYER: _____ PHONE# _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

INSURED'S INFORMATION

NAME: _____ RELATIONSHIP TO PATIENT _____

DOB: _____ SS#: _____

ADDRESS _____

HOME PHONE: _____ WORK PHONE: _____

EMPLOYER: _____

GROUP# _____ POLICY/ID NUMBER _____

I HEREBY AUTHORIZE ALL MEDICAL PAYMENTS/SURGICAL BENEFITS TO BE PAID TO LUCIAN RIVELA, M.D., 9191 PINECROFT DRIVE STE 150, THE WOODLANDS, TX 77380, BY REASON OF SERVICE DESCRIBED IN THE STATEMENTS RENDERED, AND AS PROVIDED FOR IN MY INSURANCE POLICY CONTRACTS. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTO COPY OF THIS ASSIGNMENT IS CONSIDERED TO BE VALID AS AN ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. THEREBY AUTHORIZE ASSIGNEE TO RELEASE ALL INFORMATION THAT IS NECESSARY TO SECURE PAYMENTS. IF YOU ARE A COSMETIC PATIENT SIGNATURE REQUIRED FOR VERIFICATION PURPOSES.

SIGNATURE: _____ DATE: _____

HEALTH HISTORY

Patient Name: _____ Date: _____

Age: _____ Date of Birth: _____ HT: _____ WT: _____ Marital Status: _____

What is the reason for your visit: _____

MEDICAL HISTORY: Do you, or have you had any of the following?

	Yes	No		Yes	No
Rheumatic Fever/Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Skin Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Skin Sensitivity to Adhesive Tape	<input type="checkbox"/>	<input type="checkbox"/>	Large Scars or Keloids	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had psychiatric problems/been under the care of a psychiatrist?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to any question, please explain: _____

HOSPITALIZATIONS AND/OR PREVIOUS SURGERY: Please list with dates:

ALLERGIES: Are you allergic to any medications? Yes No If yes, please list medication and type of reaction (s) _____

MEDICATIONS: Please list **all medications** you are currently taking, including herbal medicines, diet pills, accutane and over-the-counter medications. _____

FAMILY HISTORY:

Check (x) if blood relatives have had any of the following:

- | | <u>Relationship to you</u> | |
|--------------------------|----------------------------|---|
| <input type="checkbox"/> | Breast Cancer _____ | |
| <input type="checkbox"/> | Skin Cancer _____ | Type of skin cancer if know _____ |
| <input type="checkbox"/> | Other skin diseases _____ | Type if known _____ |
| <input type="checkbox"/> | Keloid Scars _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> | Bleeding Disorders _____ | <input type="checkbox"/> Heart Disease/stroke _____ |
| <input type="checkbox"/> | Prolonged Bleeding _____ | <input type="checkbox"/> Other _____ |

HEALTH HABITS: Do you smoke? No Yes _____ per day

WORK STATUS: Are you currently working? Yes Occupation: _____
No Retired

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his staff responsible for errors or omissions that I may have made in completion of this form.

Signature _____ Date _____

Reviewed by _____ Date _____

Lucian J. Rivela, M.D..., P.A.

Patient Consent and Acknowledgement of Receipt of Privacy Notice

Our Notice of Privacy practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Policies.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease. the restrictions requested.

I hereby authorize Dr. Lucian J. Rivela, M.D., and/or staff to release information pertaining to my condition and/or care to only those family members (representative) and/or others involved with my care as listed below:

Name (Authorized Representative)	Relationship
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I authorize Lucian J. Rivela M.D. and his staff to contact me (or my personal representative in the following ways. ***Please check all that apply*******

- | | | | | | |
|--------------------------------|------------------------------|---------------------------------|------------------------------------|------------------------------|-----------------------------|
| <input type="checkbox"/> Phone | <input type="checkbox"/> Fax | <input type="checkbox"/> E-Mail | <input type="checkbox"/> U.S. Mail | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| (Office Promotions) | | | (Office Promotions, Etc.) | | |

E-Mail Address: _____

Patient's Signature	Date
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- If not signed by patient, please indicate relationship:
- () parent or guardian of minor patient under 12 years old
 - () guardian or conservator of incompetent patient