Houston Methodist Sugar Land Neurology Associates

16605 SW Freeway, Suite 600
Sugar Land, TX 77479
(281) 274-7595 Office (281) 494-6410 Fax

Carisa Liew, D.O. **Rony Ninan, M.D.**
Larry Tran, M.D. **Toby Yaltho, M.D.**

Board Certified in Adult Neurology

We appreciate the trust you've placed in us to provide your specialty care. The following information clarifies our respective responsibilities in providing and receiving information. Our patient care procedures have been developed over time to maximize your visit experience and outcome.

New Patients: New patients are usually referred to us by their primary care physician or other specialist. If you have received diagnostic testing of any kind (x-ray, MRI, CT, laboratory) related to this visit, please bring the test results with you or have them forwarded to us prior to your visit.

If you are insured with an HMO, your primary care physician will provide a written referral that includes their diagnosis for referral. Without a referral, we will not be able to bill your insurance and you may be asked to pay in full at the time of visit.

Please bring the following:

- Written referral – HMO insurance only
- Results of tests ordered by referring MD
- New patient forms
- Insurance card
- Photo ID

Appointments: We attempt to contact patients 24-48 hours prior to their appointment. Our schedule is usually booked several weeks in advance, so we ask for at least one business day notice for cancellation. **Failure to notify our office of cancellation at least one full business day prior to your scheduled appointment or not appearing for your scheduled appointment may result in a No- Show fee.**

Test Results: Test results are given during a follow-up visit only. You will be asked to schedule an appointment to discuss results of any tests ordered by our physicians to avoid misunderstandings and improve the patient care outcome. Please do not contact the office for a copy, fax, or verbal disclosure prior to your follow-up appointment. NOTE: You will be contacted should any result require action prior to your scheduled follow-up appointment.

Forms: We will not complete disability, FMLA, or functional capacity evaluation forms.

Refills: Medications prescribed by our physicians may be refilled if you have been seen within the last year. Refills will not be approved after office hours or on weekends. We do not call mail order pharmacies as they require a written prescription.

Signature of Acknowledging Party:	Date:

HOUSTON Methodist LEADING MEDICINE

Houston Methodist Sugar Land Neurology Associates

16605 SW Freeway, Suite 600
Sugar Land, TX 77479
(281) 274-7595 Office (281) 494-6410 Fax

PAST MEDICAL HISTORY
COMPLETE IN DETAIL

Patient Name: ____________________________ Patient Date of Birth:________________ Date: _____________

SURGICAL HISTORY *(CHECK BOXES THAT APPLY TO YOUR PAST SURGICAL HISTORY)*

Appendectomy Cataract Gyn Surgery Gallbladder Tonsillectomy Hernia
Heart Surgery Pacemaker Other Surgeries:____

MEDICAL HISTORY *(CHECK BOXES THAT APPLY TO YOUR PAST MEDICAL HISTORY)*

High Blood Pressure Diabetes Seizures Heart Disease Migraine Stroke
Thyroid Disease High Cholesterol
Cancer (Type of Cancer)____
Other Medical or Neurological Problems____

CURRENT MEDICATIONS & DOSAGE ***please complete in detail***

SOCIAL HISTORY

Smoking? No Yes (If yes, please list how many packs per day and for how many years you have smoked)
____Packs per day for ____year(s). Date Quit Smoking___________

Alcohol? No Yes (If yes, please indicate the number of drinks per day, number of years, and type(s) of alcohol used)
____drink(s) per day for ____year(s). Type(s) of drinks Beer Wine Mixed Drinks
Never used alcohol Hospitalized for alcohol use

EMPLOYMENT Job Title____

Exposures: Noise Chemicals Toxins Fumes Gases

EDUCATION Highest level Achieved____

FAMILY HISTORY *(please list those people in your family with the following illnesses):*

High Blood Pressure: _________________________________ Heart Disease: ______________________________________
Diabetes: ____ Cancer: ____
Stroke: ____ Migraine: ____
Seizures: ____ Parkinson's: ____
Alzheimer's: _______________________________________ Other Neurological Problems:

____

Patient Symptoms

			If Yes, please explain
Constitutional Symptoms			
Good general health lately:	No	Yes	______
Recent weight change:	No	Yes	______
Fever:	No	Yes	______
Fatigue:	No	Yes	______
Headaches:	No	Yes	______
Eyes			
Eye disease or injury:	No	Yes	______
Wear glasses / contact lens:	No	Yes	______
Blurred or double vision:	No	Yes	______
Glaucoma:	No	Yes	______
ENT			
Hearing loss or ringing:	No	Yes	______
Nose bleeds:	No	Yes	______
Swollen glands in neck:	No	Yes	______
Cardiovascular			
Heart trouble:	No	Yes	______
Chest pain or angina pectoris:	No	Yes	______
Palpitation:	No	Yes	______
Shortness of breath with walking or laying flat:	No	Yes	______
Swelling of feet, ankles or hands:	No	Yes	______
Respiratory			
Chronic or frequent coughs:	No	Yes	______
Spitting up blood:	No	Yes	______
Shortness of breath:	No	Yes	______
Asthma or wheezing:	No	Yes	______
Gastrointestinal			
Change in bowel movements:	No	Yes	______
Nausea or vomiting:	No	Yes	______
Rectal bleeding or blood in stool:	No	Yes	______
Abdominal pain or heartburn:	No	Yes	______
Peptic ulcer (stomach or duodenal):	No	Yes	______
Genitourinary			
Frequent urination:	No	Yes	______
Burning or painful urination:	No	Yes	______
Blood in urine:	No	Yes	______
Incontinence or dribbling:	No	Yes	______
Kidney stones:	No	Yes	______

Patient Name:______________________ Date:____________

Patient Symptoms (cont.)

Musculoskeletal			If Yes, please explain
Joint pain:	No	Yes	______
Joint stiffness or swelling:	No	Yes	______
Weakness of muscles or joints:	No	Yes	______
Muscle pain or cramps:	No	Yes	______
Back pain:	No	Yes	______
Cold extremities:	No	Yes	______
Difficulty in walking:	No	Yes	______
Integumentary (skin)			
Rash or itching:	No	Yes	______
Change in skin color:	No	Yes	______
Varicose veins:	No	Yes	______
Neurological			
Frequent or recurring headaches:	No	Yes	______
Lightheaded or dizzy:	No	Yes	______
Convulsions or seizures:	No	Yes	______
Numbness or tingling sensations:	No	Yes	______
Psychiatric			
Memory loss or confusion:	No	Yes	______
Nervousness:	No	Yes	______
Depression:	No	Yes	______
Insomnia:	No	Yes	______
Endocrine			
Excessive thirst or urination:	No	Yes	______
Heat or cold intolerance:	No	Yes	______
Hematologic / Lymphatic			
Bleeding or bruising tendency:	No	Yes	______
Anemia:	No	Yes	______
Phlebitis:	No	Yes	______
Past transfusion:	No	Yes	______

Allergies: History or Reaction to Medicines or Other Agents

Penicillin: No Yes

Other antibiotics: No Yes (list): ______

Morphine, Demerol, or other narcotics: No Yes

Novocain or other anesthetics: No Yes

Aspirin or other pain remedies: No Yes

Iodine, methiolate or other antiseptic: No Yes

Tetanus antitoxin or other serums: No Yes

Other drugs / medications: ______

Patient Name: ______ Date: ______

HOUSTON Methodist LEADING MEDICINE

Houston Methodist Sugar Land Neurology Associates

16605 SW Freeway, Suite 600
Sugar Land, TX 77479
(281) 274-7595 Office (281) 494-6410 Fax

PERMISSION TO DISCLOSE RELEVANT HEALTH INFORMATION TO FRIENDS AND FAMILY

We value your privacy and ask that you help us identify the persons whom you would like us to discuss your health care. (Including, but not limited to: test results, recent visits, medication requests, appointment information, and billing/insurance information).

I GIVE PERMISSION for TMH Physician Organization dba Methodist Sugar Land Neurology Associates to disclose relevant health information to my family members and to the individual(s) I have listed below:

1st Name: ___________________________________ Relationship_____________________________

Phone:__________________________________

2nd Name: ___________________________________ Relationship_____________________________

Phone: ___________________________________

3rd Name: ___________________________________ Relationship_____________________________

Phone: ___________________________________

4th Name: ___________________________________ Relationship ____________________________

Phone: ___________________________________

____
Patient Name

____ _____________
Signature of Patient or Patient's Qualified Personal Representative Date

____
Printed Name of Qualified Personal Representative

____
Legal Authority to Act on Behalf of the Patient

***This does not authorize copies of PHI to be mailed or faxed to the persons listed. To obtain copies of PHI a valid HIPAA release is required**