NEW PATIENT
REGISTRATION FORM

Baytown Internal Medicine Associates, PLLC
Imran Siddiqui, MD
4308 Allenbrook Dr.
Baytown, TX, 77521
Phone: (832) 422-4141 | Fax: (281) 422-5939

PATIENT NAME: _____ **DOB:** _____

PATIENT INFORMATION

Social Security Number: _____ Sex:☐ MALE ☐ FEMALE _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Is it okay to send appointment updates via email? ☐ YES ☐ NO Text?☐YES ☐ NO

RACE: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Other: _____

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other: _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered

PRIMARY LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ OTHER: _____

EMERGENCY CONTACT NAME: _____

Relationship: _____ Phone: _____

PHARMACY PREFERENCE

PHARMACY INFORMATION: (Name & Phone Number): _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

Policy Number: _____ Group Number: _____

Primary Insured Name (if not patient): _____ DOB: _____

SECONDARY INSURANCE (if applicable): _____

Policy Number: _____ Group Number: _____

Primary Insured Name (if not patient): _____ DOB: _____

REFERRAL INFORMATION

Patient Referred by: _____

Referring Provider's Phone Number: _____ Today's Date: _____

Reason for today's visit: _____
_____
_____

HEALTH HISTORY
QUESTIONNAIRE

Baytown Internal Medicine Associates, PLLC
Imran Siddiqui, MD
4308 Allenbrook Dr.
Baytown, TX, 77521
Phone: (832) 422-4141 | Fax: (281) 422-5939

PATIENT NAME: _____DOB: _____

This Health History Questionnaire is meant to provide your care team with important information regarding your health and health goals. All information contained in this questionnaire will remain strictly confidential and will become part of your medical record, so please answer all questions as completely and accurately as possible.

DEMOGRAPHICS & HOUSEHOLD

Marital Status: ☐Single ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed # of children: _____

Occupation: _____ Are you retired?: ☐NO ☐YES

Primary Care Provider: _____ Phone: _____

Please list any other providers you are seeing (include specialty)_____
_____

CURRENT MEDICATIONS

Check here ☐ if you do not take any prescription or over-the-counter medications.

Check here ☐ if you brought a list of your current medications. (No need to rewrite medications below.)

Please list all medications that you are currently taking including prescriptions, over the counter (Advil, Tylenol, Motrin, Aleve, etc.), vitamins, supplements, home remedies, birth control pills, inhalers, and sprays.

MEDICATION NAME	DOSE (MG, PILL, ETC.)	HOW MANY TIMES PER DAY?

Check here if you do not have any known allergies to medication.

Please list any medications you are allergic to and describe the reaction.

MEDICATION NAME	DESCRIBE YOUR REACTION

ALLERGIES & IMMUNIZATIONS

Do you have a latex allergy? ☐ NO ☐ YES

Do you have any food or environmental allergies? ☐ NO ☐ YES *If yes, please describe below.*

I am allergic to: _____
_____

I carry emergency epinephrine with me at all times. ☐ NO ☐ YES

Please check all immunizations that you've received and write in the year if known.

☐ Tetanus (Td) _____ ☐ with Pertussis (Tdap) _____ ☐ Varicella (chickenpox) shot or illness ____

☐ Pneumovax (pneumonia) _____ ☐ Annual Flu Shot _____ ☐ Hep A _____ ☐ Hep B _____

☐ MMR (measles, mumps, rubella) _____ ☐ Meningitis _____ ☐ Shingles _____ ☐ HPV ____

HOSPITALIZATIONS & INTERVENTIONS

Please list any past surgeries and include the year and facility/location.
Check here ☐ if you have no surgical history.

	Surgery	Year	Facility / Location
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Please list any past hospitalizations and include the year and facility/location.
Check here ☐ if you have no history of being admitted to a hospital. (This does not include ER visits.)

	Reason for Hospitalization	Year	Facility / Location
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Please list any past hospitalizations and include the year and facility/location.
Check here ☐ if you have no history of being admitted to a hospital. (This does not include ER visits.)

	Exam / Procedure	Year	Findings / Outcome
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

PATIENT HEALTH HISTORY

Please check any of the following conditions that apply to you.

Check here ☐ If you have no history of any significant medical conditions or illnesses.

- ☐ Alcohol or drug abuse
- ☐ Anemia
- ☐ Complication from anesthesia
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Birth defect
- ☐ Bladder disorder
- ☐ Bleeding disorder
- ☐ History of blood clots
- ☐ History of blood transfusion
- ☐ Bowel disease
- ☐ Breast cancer
- ☐ Cervical cancer
- ☐ Colon cancer
- ☐ Depression
- ☐ Diabetes: ☐ Type 1 ☐ Type 2
- ☐ Growth/development disorder
- ☐ Hearing impairment
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart pain, angina
- ☐ Hepatitis ☐ A ☐ B ☐ C ☐ D
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV
- ☐ Hives
- ☐ Kidney disease
- ☐ Liver cancer
- ☐ Liver disease
- ☐ Lung cancer
- ☐ Lung or respiratory disease
- ☐ Mental illness
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Prostate cancer
- ☐ Rectal cancer
- ☐ Reflux or GERD
- ☐ Seizures, convulsions, or epilepsy
- ☐ Severe allergy
- ☐ Sexually transmitted disease
- ☐ Skin cancer
- ☐ Stroke or CVA
- ☐ Suicidal ideation or attempt
- ☐ Thyroid disorder
- ☐ Ulcer
- ☐ Visual impairment

FAMILY HISTORY

Please complete the following as it relates to your immediate biological family including parents, grandparents, siblings, and children.

Check here ☐ If you are adopted and/or do not have access to your biological family medical information.

Check here ☐ If there is no history of significant disease in your immediate biological family to report.

CONDITION	RELATIVE	CONDITION	RELATIVE
Alcoholism / Drug abuse		High cholesterol	
Alzheimer's or dementia		Kidney disease or stones	
Asthma		Leukemia	
Autoimmune disease		Lung / respiratory disease	
Bleeding disorder		Migraines	
Breast cancer		Osteoporosis	
Colon cancer		Other cancer:	
Depression		Thyroid disorder	
Diabetes: ☐ type 1 ☐ type 2		Seizure disorder, epilepsy	
High blood pressure		Severe allergy	
Heart disease		Stroke, CVA	

SOCIAL HISTORY				
Alcohol	Do you drink alcohol?_____	☐ Y ☐ N	If yes, how many drinks/week? _____	
	What kind of alcohol do you consume? _____			
	Do you 'binge' drink?_____	☐ Y ☐ N	Do you experience blackouts?	☐ Y ☐ N
Tobacco	Do you use tobacco?_____	☐ Y ☐ N	If yes, how much/day? _____	
	How many years using?_____	☐ Y ☐ N	If you quit, what year was it? _____	
Drugs	Do you use illegal drugs?_____	☐ Y ☐ N	Have you used a needle?	☐ Y ☐ N
	Check here ☐ if you would like to discuss this with a provider.			
Sex	Are you sexually active?_____	☐ Y ☐ N	If yes, are you trying for pregnancy?	☐ Y ☐ N
	If no, what contraceptive or barrier method are you using? _____			
	Any discomfort with intercourse?__	☐ Y ☐ N	Do you wish to discuss HIV risk?	☐ Y ☐ N

OTHER INFORMATION

Do you have Advance Directives? ☐ NO ☐ YES If yes: ☐ Living Will ☐ DNR ☐ POLST

(Advance directives are written, legal instructions regarding your preferences for medical care if you become unable to make medical decisions for yourself.)

Do you have a designated Power of Attorney? ☐ NO ☐ YES

If yes, my POA is: _____ Relationship: _____

If yes, I have provided a copy of my Power of Attorney paperwork to be added to my chart. ☐ NO ☐ YES

Do you have any religious or cultural beliefs that may impact your healthcare? ☐ NO ☐ YES

If yes, please explain: _____

Highest level of education: ☐ Some high school ☐ High school grad or GED ☐ 1–4 yrs of college ☐ 4+ yrs of college

INFORMATION REVIEW

I, _____, have reviewed the information provided above and acknowledge that the information provided is true, accurate, and complete to the best of my ability.

Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____

PATIENT BILL OF RIGHTS

Baytown Internal Medicine Associates, PLLC
Imran Siddiqui, MD
4308 Allenbrook Dr.
Baytown, TX, 77521
Phone: (832) 422-4141 | Fax: (281) 422-5939

As a patient receiving medical care, you have the following rights:

- The right to respectful and considerate care, free from discrimination based on race, ethnicity, religion, gender, sexual orientation, age, or disability.
- The right to receive accurate and easily understood information about your health condition, treatment options, and expected outcomes.
- The right to participate in decisions about your care, including the right to refuse treatment.
- The right to access your medical records and to request corrections to any inaccuracies.
- The right to privacy and confidentiality of your medical information, as protected by federal and state laws.
- The right to receive timely and appropriate medical care, regardless of your ability to pay.
- The right to receive information about the cost of your care, including itemized bills and explanations of charges.
- The right to a safe and clean environment for medical treatment.
- The right to file a complaint or appeal with the healthcare provider or a regulatory agency without fear of retaliation.
- The right to receive information about how to file a complaint or appeal, including contact information for the appropriate regulatory agency.

We value your rights as a patient and will make every effort to ensure that they are respected and protected.

If you have any questions or concerns about your care, please speak with your healthcare provider or contact the appropriate regulatory agency.

PATIENT INITIALS: _____

Date: _____

HEALTH INFORMATION
EXCHANGE CONSENT

Baytown Internal Medicine Associates, PLLC
Imran Siddiqui, MD
4308 Allenbrook Dr.
Baytown, TX, 77521
Phone: (832) 422-4141 | Fax: (281) 422-5939

Patient Name (Print): _____ DOB: _____

I, the above-named patient, hereby authorize the electronic exchange of my protected health information (PHI) through the Health Information Exchange (HIE) network.

I understand that the purpose of the HIE is to improve the quality, safety, and efficiency of my healthcare by allowing my healthcare providers to securely access and share my PHI with each other. I understand that the information exchanged may include, but is not limited to, the following:

- Medical history and diagnoses
- Medications and allergies
- Lab and test results
- Imaging reports
- Discharge summaries
- Treatment plans and progress notes

I understand that my PHI will only be exchanged between healthcare providers who are involved in my care and who have a legitimate need for the information. I understand that my PHI will be protected by state and federal laws governing the privacy and security of health information.

I have the right to revoke this consent at any time by notifying the HIE in writing. I understand that if I revoke this consent, it will not affect any actions taken prior to the revocation.

I have received a copy of the Notice of Privacy Practices, which explains in detail how my PHI may be used and disclosed, and I understand my rights and responsibilities with respect to my PHI.

By signing below, I acknowledge that I have read this consent form, understand its contents, and agree to the electronic exchange of my PHI through the HIE network.

Patient Signature: _____ Date: _____

Representative Name: _____ Relationship: _____

Witness Signature: _____ Date: _____

FINANCIAL
RESPONSIBILITY AGREEMENT

Baytown Internal Medicine Associates, PLLC
Imran Siddiqui, MD
4308 Allenbrook Dr.
Baytown, TX, 77521
Phone: (832) 422-4141 | Fax: (281) 422-5939

Patient Name (Print): _____ DOB: _____

I, the above-named patient, understand that I am financially responsible for all services provided to me by IMRAN SIDDIQUI dba BAYTOWN INTERNAL MEDICINE.

- I agree to pay for all services provided to me by the healthcare provider or clinic at the time services are rendered.
- I agree to provide accurate and complete insurance information and to notify the healthcare provider or clinic of any changes in my insurance coverage. I understand that I am responsible for any amounts not covered by my insurance plan.
- I acknowledge that I am responsible for paying any co-payments, deductibles, or other out-of-pocket expenses at the time of service. If I am unable to pay for the services provided, I agree to make payment arrangements with the healthcare provider or clinic.
- I authorize the healthcare provider or clinic to release any necessary information to my insurance company or any other party responsible for payment of my healthcare services.
- I agree to provide the healthcare provider or clinic with updated contact information, including my mailing address, phone number, and email address.
- I understand that failure to pay for services provided may result in the healthcare provider or clinic taking legal action to collect payment, and that I may be responsible for any legal fees and expenses incurred by the healthcare provider or clinic in such an action

By signing below, I acknowledge that I have read and understand the financial responsibility agreement and agree to comply with its terms.

Patient Signature: _____ Date: _____

Representative Name: _____ Relationship: _____

CONSENT TO MEDICAL TREATMENT

Baytown Internal Medicine Associates, PLLC
Imran Siddiqui, MD
4308 Allenbrook Dr.
Baytown, TX, 77521
Phone: (832) 422-4141 | Fax: (281) 422-5939

Patient Name (Print): _____ DOB: _____

I, the above-named patient, hereby give my informed consent to IMRAN SIDDIQUI dba BAYTOWN INTERNAL MEDICINE and any other healthcare providers who may be involved in my care to provide medical treatment, examinations, procedures, and diagnostic tests as deemed necessary for my health condition.

- I understand that the purpose of this medical treatment is to address and manage my health condition, and that there may be alternative treatments or procedures available that have not been recommended to me.
- I understand that the healthcare providers involved in my care may need to disclose my protected health information to other healthcare providers involved in my treatment, for the purpose of coordinating my care.
- I understand that the healthcare providers will make every effort to maintain the confidentiality of my protected health information, but that there may be certain situations where disclosure may be required by law, such as reporting of communicable diseases or suspected child abuse.
- I have had the opportunity to ask questions about the proposed treatment, and my questions have been answered to my satisfaction. I have been given a reasonable explanation of the risks, benefits, and alternatives to the proposed treatment, and I understand the potential consequences of refusing treatment.
- I understand that I have the right to revoke this consent at any time, except to the extent that action has been taken in reliance on it.

I certify that I have read and fully understand the above information, and that I have had an opportunity to ask questions about the proposed treatment. I voluntarily consent to receive medical treatment, examinations, procedures, and diagnostic tests as deemed necessary by my healthcare providers.

Patient Signature: _____Date: _____

Representative Name: _____Relationship: _____

Provider Signature: _____Date: _____

Baytown Internal Medicine

4308 Allenbrook Dr. Baytown, TX 77521

PATIENT'S STATEMENT OF FINANCIAL RESPONSIBILITY and Our Financial Policies

Thank you for choosing my office for your Primary Healthcare Services. I'm sure you already understand that as you depend on us to care for you, we depend on you to accept your payment responsibility for the care you receive. I hope you agree it's a partnership.

— Dr. Imran Siddiqui —

If there is anything here that you do not understand, please ask!

Please check off each provision in the space to its left:

___ I authorize insurance benefits, if any, to be paid directly to Baytown Internal Medicine. I understand I am responsible for co-pays, co-insurance, deductibles, and non-covered benefits according to the insurance company's explanation of benefits.

___ I will notify you (the office) of changes to my phone numbers, billing address, or other billing or insurance information within 10 days of a change.

___ If I miss an appointment without calling to cancel at least 24 hours before the appointment, I agree to pay a $49 fee for "Missed Appointment without Notice." ***(Please note: We do consider the circumstances of a missed appointment and may waive the fee at our discretion.)***

___ I agree to pay balances due on my account within 60 days of your statement's date.
(Details: After 60 days past the statement date, late fees, collection fees, and interest charges may be added. Scheduled appointments may be cancelled, and further appointments may not be allowed without payment of past due balances. Late fees are per date of service and are $15 at 61 days past the statement date and $30 at 91 days past the statement date. Interest charges of 12% per annum and collection agency fees of 28% to 50% of amounts to be collected may also be added.)

We accept Cash, Visa, MasterCard, Discover, American Express & Checks. We accept payment by phone using credit card. Checks are immediately processed through TeleChek®. We do not accept "post-dated" checks. We charge $32.50 for returned checks.

With my signature here, I agree that I have read and understand the policies and terms described above.

_____ _____

Signature of Patient, Power of Attorney, or Guardian if minor Date

Baytown Internal Medicine

4308 Allenbrook Dr. Baytown, TX 77521

PATIENT CONSENT
FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent below, Baytown Internal Medicine (the Practice) may obtain and disclose Protected Health Information about me **including Prescription Histories, Medical Records and/or Insurance Information from Pharmacies, Hospitals, Insurance Companies and/or other Physicians** to carry out healthcare and payment operations. I understand this information may be viewable by any of the Practice's providers and staff. This consent also assigns insurance benefits to the Practice. (I understand that I am financially responsible for any charges considered by the Insurer to be my responsibility including those not covered by my health care benefits.)

I have the right to review the Practice's Notice of Privacy Practices (available on request) prior to signing this consent. However, the Practice reserves the right to revise its Notice of Privacy Practices at any time. Any revised Notice of Privacy Practices may be obtained by forwarding a written request to **Baytown Internal Medicine, Attn: Privacy Officer, 4308 Allenbrook Dr., Baytown, TX 77521**

In accordance with my consent below, the Practice may call or mail to my home or other designated location and may leave a message on voice mail or with persons listed below with reference to any items that assist the practice in carrying out its general scheduling, healthcare, billing and/or insurance operations, including appointment reminders, insurance items and requests for call-back about my clinical care, including laboratory results.

Preferred modes of contact: ( ) Home Ph. ( ) Cell Ph. ( ) Cell Ph. Text Msg ( ) Work Ph. ( ) Email

Email address: _____

Preferred mode of contact for Protected Health Information: ( ) Home Ph. ( ) Cell Ph. ( ) Work Ph.
Note: Protected Health Information will not be sent via fax or email.

Names & Relationships of Persons who may receive my Protected Health Information:

Name _____ Relation: _____ Phone: _____

Name _____ Relation: _____ Phone: _____

Name _____ Relation: _____ Phone: _____

I have the right to request the Practice restrict how it uses or discloses my Protected Health Information to carry out its treatment, payment and healthcare operations. The practice is not required to agree to my requested restrictions, but if it does agree, then it is bound by this agreement.

By signing this form, I am consenting to the Practice's use and disclosure of my Protected Health Information for treatment, payment and healthcare operations. I authorize direct remittance of all insurance payments by Assignment to Baytown Internal Medicine. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the Practice may decline to provide treatment.

Signature of Patient or Legal Guardian _____ Print Patient's Name _____

Date _____Print Name of Legal Guardian (if not Patient) _____

Nurse Practitioner
Consent for Treatment
Baytown Internal Medicine.

This facility has on staff a Nurse Practitioner to assist in the delivery of medical care.

A Nurse Practitioner is not a doctor. A Nurse Practitioner is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a Nurse Practitioner can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A Nurse Practitioner may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulation a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above, and hereby consent to the services of a Nurse Practitioner for my health care needs.

I understand that at any time I can refuse to see the Nurse Practitioner and request to see a physician.

NAME:	DATE:
SIGNATURE:	WITNESS: (OPTIONAL)

Baytown Internal Medicine Associates
4308 Allenbrook Drive
Baytown, TX. 77521
AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name _____ Date of Birth: _____

Telephone: _____ SSN (optional): _____

Release my records ☐ From ☐ To (pick one) Release my records ☐ From ☐ To (pick one)

Dr.: _____

Phone: _____

Fax: _____

Imran Siddiqui MD
4308 Allenbrook Dr.
Baytown, Tx. 77521
Office: 281-422-4141
Fax: 281-422-5939

I ☐ do ☐ do not (check applicable box) authorize this information to be faxed.
I request disclosure for the purpose of ☐ Continuing Health Care ☐ Other _____

Please send Medical Records covering period ☐ All or ☐ From: _____ (MM \ YY) To: _____ (MM \ YY)

☐ History and Physical Exam ☐ X-Ray/Ultrasound/EKG ☐ Recent/Current Medications

☐ Progress Notes ☐ Laboratory Tests ☐ Immunizations

☐ Consultations/Studies ☐ Discharge Summaries ☐ Other: _____

Restrictions: I understand that the recipient of this information may not use this information except for the express purpose identified above, unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Notice: Unless specified below this authorization is for full disclosure of all records, including clinical findings, diagnoses, treatments, assessments, recommendations for further care, names of all health care personnel, dates of hospitalizations and ambulatory visits, charges and any information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted disease, including AIDS/HIV information except as excluded below.

Exclusions: ☐ Drug/Alcohol ☐ HIV/AIDS ☐ STD ☐ Mental Health/Psychiatric

Unless otherwise indicated, this authorization will expire ninety (90) days from the date of signature. The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization for the purposes stated above.

I understand that for purposes other than Continuing Health Care, fees may be charged for preparing and furnishing this information.

Signature of Patient or Legal Representative: Relationship to Patient: Date: