Gabriel Maislos, DPM
Haonan Tom Lin, DPM
2900 Weslayan #650
Houston, TX 77027
713-541-3199
713-541-5809

Date: _____

Last Name : _____ First Name: _____

Address: _____ Date of birth : _____

City: _____ State : _____ Zip : _____

Phone 1 : _____ Phone 2: _____

Email address : _____

Sex : _____ Race : _____ How did you hear about us : _____

Marital Status : M D S W Occupation: _____

Primary Care Doctor : _____ Telephone : _____

Pharmacy Name : _____

Address : _____ Telephone: _____

Emergency Contact : _____ Telephone: _____

Relationship: _____

Insurance Name : _____ ID # _____
(If not already provided to receptionist)

Authorization of Benefits and Release of Information

I hearby authorize the medical / surgical benefits otherwiese payable to me for services rendered to be paid directly to the physican providing care. I hereby authorize Dr. Maislos to release any information required by my insurance company to process claims, regardless of insurance coverage. I am responsible for all bills being paid and in a timely manner.

Our office collects all co-pays and deductibles at the time of service.
The amount collected is only a quote of your benefits and not a guarantee. You may still owe an additional amount after your claim has been processed.

_____

Name : _____ Date:_____

What brings you into the office today ? _____

Current Medications :

Name of Medication:	Dosage / How often :	For what Condition :

Medication Allergies : _____

Foods Allergies : _____

Reaction : _____

Past Medical History : (Circle all that apply)

Frequent Headaches	Tuberculosis	Prostate Issues	Asthma
Rheumatic Fever	Emphysema	Chest Pain	Shortness of Breath
Kidney Disease	Heart Problems	Gout	Sexually
Dialysis	Stroke / TIA	High Cholesterol	Transmitted disease
Diabetes -	Tumor / Cancer	Hepatitis A B C	Pacemaker
Insulin Dependent	Pneumonia	HIV / Aids	Stents
Non - Insulin Dependent	Bleeding	Drug / Alcohol Abuse	
Anemia / Blood Disorder	High Blood Pressure	Stomach Ulcers	Other:
Lupus	Emotial Problems	Arthritis	

Name: _____ Date:_____

Surgical History :

Surgical Procedures :	Year:	Physician:

Family History :

Mother : Alive Deceased

Father: Alive Deceased

Do you have a family history of any of the following:

High Blood Pressure	Stroke
Diabetes	Cancer Type
Heart Disease	Mental Disorder

Social History:

Do you smoke : cigarettes / cigars / vape ? Yes No Never

If yes, how much / many per day ? _____

If not how long ago did you quit ? _____

Do you consume Alcohol ? Yes No

If yes, how much alcohol do you consume per week _____

Height _____ Weight _____ Shoe size _____

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclose

d to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restrictions requested and to whom you want the restrictions to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclose your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means at an alternative location. You also have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, or of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by telephone at our Main Office.

HIPAA Privacy Consent

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications or that a communication of protected health information be made by alternative means, such as sending correspondence to the individual's office instead of the individual's office instead of the individual's home.

I allow you to give my information or answer questions with the following individual(s):

Name	Relationship	Phone Number

Signature below is only acknowledgment that you have received, read, and reviewed this Notice of our Privacy Practices.