New Wave Physicians Group, PLLC
5220 FM 2920, Ste. 110, Spring, TX 77388 PH: 713-429-0881
13480 Veterans Memorial Dr. Ste. R1, Houston, TX 77014 PH: 281-587-1600

FAX: 832-698-9568
Dr. Amie Sun-Wright Dr. Tam Truong Dr. Timothy Carder Dr. Sushma Gorrela Dr. Afua Agyarko
Dr. Louis Jin Maribel Anaya, PA Maribel Montano, NP Amanda Mcguire, NP

PATIENT REGISTRATION FORM

Today's Date _____ Doctor_____

Name _____ SSN _____ Date of Birth _____
First Middle Last (MM/DD/YYYY)

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cellular Phone _____ Work Phone _____

Email _____

Employer _____ Occupation _____

Race: ☐ *Caucasian* ☐ *African American* ☐ *Asian* Ethnicity: _____

☐ *American Indian or Alaska Native* ☐ *Pacific Islander or Native Hawaiian*

Language: _____

Gender: ☐ *Male* ☐ *Female* ☐ *Non-Binary* ☐ *Other* **Marital Status:** ☐ *Single* ☐ *Partnered* ☐ *Married* ☐ *Divorced* ☐ *Widowed*

Spouse Name _____ Spouse Date of Birth _____
(If Applicable) First Middle Last (MM/DD/YYYY)

Emergency Contact _____ Emergency Contact Phone _____
First Middle Last

How did you hear of NWPG: ☐ *Internet Search* ☐ *Social Media* ☐ *Print/Ad.* *Referred By* _____

IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT, PLEASE COMPLETE THIS SECTION

Name _____ SSN _____ Date of Birth _____

Relationship to Patient _____ Contact Phone _____

Mailing Address _____

Employer _____ Work Phone _____

NOTICE TO PATIENTS REFERRED TO IMAGING SERVICES

By my signature below, I understand that Federal and Texas law requires physicians to disclose financial or ownership interests in referring entities. As there are suppliers available to offer similar services to any referring entity, you are free to use other suppliers of these services, if you prefer.

CONSENT FOR COMMUNICATION VIA EMAIL/TEXT/PHONE

New Wave Physicians Group is dedicated to keeping your medical records information confidential. I understand that this office is not responsible for information loss or delays or for breaches in confidentiality that are caused by technical factors beyond this office's control. By my signature below, I agree that New Wave Physicians Group may send medical related correspondence to me via email, text or phone and they may respond back to me using the phone and email address listed in my patient registration form.

APPOINTMENT CANCELLATIONS/NO SHOWS

By my signature below, I acknowledge that I may be charged a **fee of $50** (not covered by insurance) for missing my appointment, arriving more than 20 minutes late, or cancelling my appointment without 24 hours' notice unless written proof of extenuating services is provided.

ASSIGMENT OF INSURANCE BENEFITS AND AUTHORIZATION FOR RELEASE OF INFOMATION

By my signature below, I requested that payment of authorized Medicare or other insurance benefits be made on my behalf to New Wave Physicians Group for any service furnished to me by one of the providers associated with the practice. I authorize any holder of medical information about me to release to the health care financing administration (HCFA), its agents and/or my Medigap or other insurer any information needed to determine these benefits or the benefits payable for related services. This authorization shall continue until such time as I revoke it in writing.

CONTROLLED SUBSTANCES

Please be advised that effective January 1, 2022, only limited quantities of pain medications for acute pain will be prescribed. All patients being prescribed said medications will be asked to sign a pain management agreement. Failure to agree and comply with the said terms on the agreement will result in denial of such medications. Patients that require additional and /or long-term management of their pain symptoms, will possibly be referred to pain management for additional evaluation and treatment.

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician and/or other individuals he or she deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to New Wave Physicians Group unless revoked by me orally or in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with aids, in the following situations:

1. To screen blood, blood products, organs, or tissues to determine suitability for donation or
2. If another individual is accidentally exposed to a patient's blood or body fluids, such as through a needle stick (any such test shall be conducted pursuant to New Wave Physicians Group infectious disease protocol) or
3. If a medical or surgical procedure is to be performed which could exposure health care workers to the patient's blood or body fluids.

This disclosure is to inform you that you may be tested at the expense of New Wave Physicians Group. If any of these situations occur during your treatment period.

_____ _____

Patient Printed Name Patient Date of Birth

_____ _____

Patient / Guardian Signature Relationship to Patient

_____

Date

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Acknowledgment of Review of Notice of Privacy Practices

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time in writing, except to the extent that your physician or the physicians' practice has taken action in reliance on the use or disclosure indicated in the authorization.

The following is a statement of your rights with respect to your protected health information:

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.

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____
Patient Printed Name Patient Date of Birth

_____ _____
Patient/Guardian Signature Relationship to Patient

_____
Date

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

In general, the HIPAA privacy rules give individuals the right to request a restriction on use and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means or communicated to authorized designated parties including family members.

I consent for my PHI to be given through the following: (**Check All That Apply**)

Home Telephone

☐ Leave a message with detailed information.

☐ Only leave a message with call back details.

Cell Phone

☐ Leave a message with detailed information.

☐ Only leave a message with call back details.

Work Telephone

☐ Leave a message with detailed information.

☐ Only leave a message with call back details.

Written Correspondence

☐ Mail to my home address on file.

☐ Email to address on file.

By my signature below, I give my authorization to discuss my protected health information (PHI), including results of laboratory tests, radiology, imaging results, and/or other test results to the following designated representatives with the doctor and staff at New Wave Physicians Group if needed.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

☐ DO NOT SHARE MY PROTECTED HEALTH INFORMATION WITH ANYONE OTHER THAN MYSELF

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

This authorization shall be valid for one (1) year from the date of the signature, unless revoked in writing by the patient prior to the expiration. As a patient, you have a right to revoke this authorization at any time, except to the extent that has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, New Wave Physicians Group must receive the revocation in writing. The revocation must include 1) The patients name, address and date of birth. 2) Patients desire to revoke the authorization. 3) The date of revocation. 4) The patients signature. All revocation must be sent in writing to the attention of: New Wave Physicians Group office at: 5220 FM 2920, Ste. 110, Spring, TX, 77388.

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION (INCOMING)

Patient Name:_____ Address:_____

Date of Birth:_____ Phone Number:_____

I authorize _____ to release medical information to **New Wave Physicians Group**
{Facility}

Fax:_____ Phone:_____

☐ Progress Notes ☐ Colonoscopy Reports ☐ Cardiology (EKG/ECHO/Stress)

☐ Lab Reports ☐ Imaging Reports ☐ Hospital/Surgical Records

☐ Immunization/Vaccine ☐ Care Plans ☐ Therapy (PT/Rehab/Home)

☐ Consult Records ☐ Eye Exam/Retina Scan ☐ DEXA Reports

"I acknowledge and hereby consent to such that the released information may contain alcohol, drug abuse, psychiatric, HIV results, or AIDS information."

This authorization covers patient care rendered from _____ to _____
{mm/dd/yyyy} {mm/dd/yyyy}

Purpose of Disclosure:

☐ Medical Care ☐ Insurance ☐ Attorney ☐ Other (specify) _____

This authorization shall be valid for _____ days from the date of signature below unless revoked in writing by the patient prior to that expiration.

☐ Yes
☐ No The patient or authorized representative agrees that a photocopy or facsimile of this authorization is considered valid.

Patient Signature _____ Date_____

Patient or Authorized Representative_____ Date_____

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HEALTH HISTORY FORM

PATIENT NAME: _____ D.O.B: _____

ALLERGIES

ALLERGY	REACTION

MEDICATION LIST

NAME	STRENGTH	INSTRUCTIONS

PAST MEDICAL HISTORY

	YOU		FAMILY		RELATIONSHIP
	Y	N	Y	N	
Alcoholism					
Allergies					
Anemia					
Angina (chest pain)					
Anxiety					
Arthritis					
Asthma					
Atrial fibrillation					
Auto immune disorder					
Bipolar disorder					
Blood clots					
BPH (enlarged prostate)					
CAD (heart disease)					
Cancer- type					
Charcot-Marie-Tooth disease					
Chronic ulcer					
Color blindness					
COPD					
Crohn's					
CVA (stroke)					
Cystic Fibrosis					
Depression					
Diabetes- type					
Gallbladder disease					
GERD (reflux)					
GI Disorder					

PAST MEDICAL HISTORY

	YOU		FAMILY		RELATIONSHIP
	Y	N	Y	N	
Glaucoma					
Gout					
Hemophilia					
Hemorrhoids					
Hepatitis					
High Blood Pressure					
High Cholesterol					
Human Papilloma virus (HPV)					
IBS (irritable bowel disease)					
Kidney disease					
Liver disease					
Lupus					
Lymphedema					
Meningitis					
MI (heart attack)					
Migraine headaches					
Mitral Valve Prolapse					
Multiple Sclerosis					
Osteoarthritis					
Parkinson's Disease					
Peptic ulcer disease					
Polio					
Polycystic Kidney					
PCOS (polycystic ovary)					
Seizure disorder					
Shingles					

HEALTH HISTORY FORM

PATIENT NAME: _____ D.O.B: _____

IMMUNIZATIONS (INDICATE YEAR OF LAST VACCINE)

TETANUS _____ Recommended every 10 years
Recommended every 5 years for age 50 and older but no more than 2 per lifetime
PNEUMONIA _____

HEPATITIS A _____ HEPATITIS B _____

INFLUENZA _____ MENINGOCOCCAL _____ SHINGLES _____

PREVENTATIVE SCREENINGS (INDICATE YEAR OF LAST EXAM)

Colonoscopy _____ Mammography _____ Carotid Doppler. _____

Cologuard _____ Pap Smear. _____ Bone Density (DEXA) _____

Eye Exam _____ Stress Test. _____ TB Test _____

EKG _____ Rectal Exam (DRE) _____ PSA _____

SOCIAL HISTORY

Do you smoke? ☐ Y ☐ N Packs per day _____ Interest in quitting? ☐ Y ☐ N

Did you stop smoking? ☐ Y ☐ N When did you quit? _____

Do you consume alcohol? ☐ Y ☐ N Type: Beer☐ Wine☐ Liquor☐ How much per week?_____

Do you consume caffeine? ☐ Y ☐ N How much per week?_____

Recreational Drugs ☐ Y ☐ N

PAST SURGICAL AND HOSPITALIZATION HISTORY

DATE	EVENT DESCRIPTION	RESON FOR EVENT

_____ _____

Patient/Guardian Signature Date

Patient Health Questionnaire (PHQ-9)

Name: _____ Date: _____

Patient DOB:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
2. Feeling down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3
3. Trouble falling or staying asleep, or sleeping too much	☐ 0	☐ 1	☐ 2	☐ 3
4. Feeling tired or having little energy	☐ 0	☐ 1	☐ 2	☐ 3
5. Poor appetite or overeating	☐ 0	☐ 1	☐ 2	☐ 3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐ 0	☐ 1	☐ 2	☐ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐ 0	☐ 1	☐ 2	☐ 3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐ 0	☐ 1	☐ 2	☐ 3
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐ 0	☐ 1	☐ 2	☐ 3

For office coding: Total Score _____ = _____ + _____ + _____

Total Score _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult