James A. Bodin, Jr. M.D.
2717 Commercial Center Blvd. STE E200
Katy, TEXAS 77494
PHONE 832-913-5039 FAX 832-913-5037

PATIENT DEMOGRAPHIC INFORMATION FORM

PATIENT INFORMATION

Gender M F	DOB	SSN	Patient ID No.		
Salutation	Last Name	First Name	Middle Name		Suffix
Patient Address (1)		City	State	Zip	
Primary Address (2)		Occupation			
Home Phone		Employer			
Work Phone	Fax No.	Spouse / Partner / Significant Other's Name			
Cell Phone		Emergency Contact			
Email Address		Emergency Phone			

INSURANCE INFORMATION

Primary Insurance

Insurance Plan Name	Group Number	ID Number			
Ins. Co Street Address	Insured's Name	Insured's DOB			
Ins. Co. Address (Line 2)	Relationship to Patient. Self S.O. Child Other	Worker's Comp			
Ins. Co. Phone Number (1)	Ins. Co. Phone No. (2)	Ins. Co. Contact Person			
City	State	Zip	Copay $		
Deductible	Amount met:	Amount Remaining	In Network?		
Ins. Co. Notes					

Secondary Insurance

Insurance Plan Name	Group Number	ID Number			
Ins. Co Street Address	Insured's Name				
Ins. Co. Address (Line 2)	Relationship to Patient. Self S.O. Child Other	Worker's Comp			
Ins. Co. Phone No. (1)	Ins. Co. Phone No. (2)	Ins. Co. Contact Person			
City	State	Zip	Copay $		
Deductible	Amount met:	Amount Remaining	In Network?		
Ins. Co. Notes					

REFERRAL INFORMATION

Referral Source	Position	Specialty	
Referral Address	City	State	Zip
Referral Address (2)	Referral Phone	Referral Fax	
Referral Question			

CONSENT TO BILLING AND MEDICAL TREATMENT

PLEASE READ: For insurance agencies or third party payors to make a payment on your behalf, we must submit limited information to them. This includes information such as the patient demographics, diagnosis, and any procedure or test results. **Your signature below signifies that you consent** to our submission of such information as needed to obtain insurance certification and reimbursement. Your signature also signifies that your are requesting and consenting to routine medical office evaluation and treatment, including physical examination, administration of medications, and procedures such as venipuncture for blood tests, local or intravenous injections, electromyography, electroencephalography, and nerve conduction testing. You agree you will not proceed with taking medications that are prescribed by this office, or undergoing procedures until your physician has explained their need and risk to your satisfaction.

(Patient, Guardian, or Medical Power of Attorney) **Signature**_____ **Date**_____

2717 Commercial Center Blvd. STE E200 Katy TX 77494

NAME: _____ **AGE:** _____ **DATE OF BIRTH:** _____

REASON FOR TODAY'S VISIT: _____

ALLERGIES and/or REACTIONS TO MEDICINES: _____

_____

CURRENT MEDICATIONS: Prescription, non-prescription medicines, vitamins, and supplements.

Medication Dose (e.g. Mg/pill) How many times/day When started

_____

_____

_____

PERSONAL MEDICAL HISTORY: Do you or have you had any of these problems? For yes answers give further details below.

YES/DATE	MEDICAL PROBLEM		YES/DATE	MEDICAL PROBLEM
	Irregular Heart Beat			Kidney Stones
	Congestive heart Failure			Kidney Disease/Infections
	Blood Clot			Breast Disease
	High Cholesterol			Fracture, which bone(s):_____
	High Blood Pressure			Arthritis
	Heart Attack			Gout
	Heart Murmur			Stroke
	Asthma			Dementia
	Skin disease, Type:_____			Cancer, Type:_____
	Pneumonia			HIV
	Pulmonary Embolism			STDs
	Tuberculosis			Blood Transfusion
	Sleep Apnea			Anemia
	Gall Stones			Bleeding Disorder
	Liver Disease/Hepatitis			Seasonal Allergies
	Hemorrhoids			Emphysema/Chronic Bronchitis
	Diabetes Type 1 (Childhood onset)			Stomach Ulcer
	Diabetes Type 2 (Adult onset)			Problems During Pregnancy
	Diverticulitis			Thyroid Disease (High/Low)
	Ulcerative Colitis/ Crohn's			Depression
	Heart Burn/ Reflux			Anxiety

Further explanation for "yes" answers:_____

_____

LIST ANY HOSPITALIZATIONS: (reason and date): _____

_____

WOMEN'S GYNOCOLOGICAL HISTORY: Sexually active: Yes / No Contraceptive Method:_____

Date of First Period:_____ Date of last Period:_____

# of Pregnancies _____ # of Deliveries _____ # of Miscarriages _____ # of Abortions_____ Menopausal: No / Yes Date _____

Last PAP smear _____ Abnormal PAP smear: Yes / No

Last mammogram _____ Abnormal mammogram: Yes / No

HEALTH MAINTENANCE: When were your most recent screening tests?

Cholesterol Screening? _____ Results? _____ PSA (Prostate cancer screen)? _____ Results? _____

Sigmoidoscopy? _____ Results? _____ Stool Test for Blood? _____ Results? _____

IMMUNIZATIONS: Please indicate the date of your most recent: Tetanus _____ Pneumovax (Pneumonia) _____

SOCIAL HISTORY: Tobacco Use: Cigarettes____ Never____ Quit: Date _____ Current Smoker: packs/day _____ # of years:_____

Other Tobacco: Pipe ____ Cigar ____ Chew _____ Interested in quitting? Yes / No

Alcohol Use: Do you drink alcohol? No / Yes, # of drinks/ week _____ Is alcohol use a concern for you or others? No / Yes

Illicit Drug use? No / Yes, Name/s of Drugs_____

SOCIOECONOMICS: Marital Status: S M D W Other: _____ Spouse/Partner's name: _____

Children: Names and Ages_____

Occupation: _____ Employer: _____Years of Education/ Highest Degree: _____

SEXUAL ACTIVITY: Sexually Active: Yes / No / Not Currently Current sex partner(s) is/are: Male _____ Female_____

EXERCISE: Do you exercise regularly? No / Yes, What kind of Exercise? _____

How long? (minutes) _____ How often? _____

SURGICAL HISTORY:

Yes/Date	Surgery		Yes/Date	Surgery
	Appendectomy			Gallbladder
	Joint Arthroscopy, Joint:_____			Joint Replacement, Joint:_____
	Heart Catheterization			Back Surgery
	Abdominal Surgery			Prostate
	Neck Artery			Vasectomy
	Open Heart/ Bypass			Tonsillectomy
	Hemia			Adenoidectomy
	Biopsy (of what?)			Cosmetic
	Broken Bone Repair			C-Section
	Sinus			Hysterectomy: Vaginal / Abdominal
	Lasik R or L			Ovaries out? Yes / No
	Cataract R or L			Other:
	Other:			Other:

FAMILY HISTORY: Please indicate with a check family members who have had any of the following conditions:

Medical condition	Mom	Dad	Sist.	Bro.	Daug.	Son	Mom's mom	Mom's dad	Dad's mom	Dad's dad	Mom's sister	Mom's bro	Dad's sister	Dad's bro
Alcoholism														
Anemia														
Anesthesia problem														
Arthritis														
Asthma														
Autoimmune disorder														
Bleeding problem														
Cancer, breast														
Cancer, colon														
Cancer, melanoma														
Cancer, ovary														
Cancer, prostate														
Heart attack (coronary artery disease)														
Birth defects														
Depression														
Diabetes, type 1 (childhood onset)														
Diabetes, type 2 (adult onset)														
Eczema														
Food Allergies														
Other genetic disease														
Hay fever														
Hearing problems														
High cholesterol (Hyperlipidemia)														
High blood pressure (Hypertension)														
Immunosuppressive disorders														
Kidney disease														
Mental Retardation														
Osteoporosis														
Epilepsy (seizure disorder)														
Stroke														
Substance abuse														
Thyroid disorders														
Smoking														
Tuberculosis														

Name: _____ Date: _____

print and sign