



RODONAIA
FAMILY MEDICINE
+ AESTHETICS

PHONE 409.923.1617 FAX 409.923.1618 EMAIL INFO@RODOMD.COM

PARK MEDICAL BUILDING 1, 2955 HARRISON AVE, STE 200

BEAUMONT, TX 77702

DATE: _____

Patient Information

Name: _____

Address: _____

City: _____ Zip Code: _____ Telephone: _____

Race: _____ DOB: _____ Male Female

Email Address: _____

Single Married Widowed Divorced

Social Security #: _____ Work #: _____

Employer: _____ Occupation: _____

Name of Spouse/Parent: _____

Spouse/Parent Phone #: _____

Insurance Information

Primary Ins Co: _____ **Ins ID #:** _____

Grp #: _____ Policy Holder: _____

Policy Holder SS #: _____ Policy Holder DOB: _____

Secondary Ins Co: _____ **Ins ID #:** _____

Grp #: _____ Policy Holder: _____

Policy Holder SS #: _____ Policy Holder DOB: _____

Emergency Contact Information

Emergency Contact Name: _____

Relationship: _____ Phone #: _____



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NAME: _____

DATE: _____

Pharmacy

Pharmacy Name: _____

Address: _____

City: _____ Zip Code: _____ Telephone: _____

Present/Past Illness

Present Aliments:

_____ Duration: _____

_____ Duration: _____

_____ Duration: _____

Past History:

_____ Date: _____

_____ Date: _____

_____ Date: _____

Allergies/Medications

Allergies: _____

Current Medications:

Family History

Age/Living-State of Health/Age at Death-Cause:

Husband/Wife: _____

Father: _____

Mother: _____

Sister(s): _____

Brother(s): _____

Family history of the following diseases:

Sugar Diabetes: Yes No **TB:** Yes No **Heart Trouble:** Yes No
High Blood Pressure: Yes No **Epilepsy:** Yes No **Cancer:** Yes No
Arthritis: Yes No **Gout:** Yes No



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DATE: _____

Dear Patient:

We look forward to seeing you for your appointment with us. Arrive 15 minutes prior to your appointment. Please bring your insurance card(s) and your co-payment (all co-pays must be paid at time of service). We accept cash or credit card. A receipt will be provided at the time of check out.

Also, you must bring photo identification with you for your first appointment. To verify, change or cancel your appointment please call (409) 923-1617 or email info@rodomd.com If you are canceling or changing your appointment please give two business days' notice.

Insurance Disclaimer:

"A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service."

Insurance Liability for Payment:

Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service.

Beneficiary Agreement: I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies. (Patient to sign and date office copy at time of visit)

Patient's Name / Date



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Patient Acknowledgement

“Notice of Privacy Practices for Physician Practices”

I _____ acknowledge receipt of Notice of Privacy Practices:

Confidential Communications Directive

I _____ authorize Rodonaia Family Medicine and Aesthetics to speak with the following family members/individuals listed below regarding my healthcare/treatment. In the event a physician should require any medical records, I authorize Rodonaia Family Management and Aesthetics to release such information via fax or mail.

1. Name: _____

Relationship: _____

2. Name: _____

Relationship: _____

3. Name: _____

Relationship: _____

Signature: _____

Date: _____



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NAME: _____

DATE: _____

Medical Records Release Form

By signing this form, I authorize Rodonaia Family Medicine & Aesthetics to receive confidential health information. I authorize permission to release medical records to the person(s) and /or entity listed below.

HIV/AIDS: I consent to the release of any positive or negative test results along with medical records to The Center for Infectious Disease.

Release my protected health information to: Records requested from:

Name: Rodonaia Family Medicine & Aesthetics

Name: _____

Address: 2955 Harrison St. Ste. 200

Beaumont, Texas 77702

Address: _____

The reason(s) or purpose for this release of information is: TREATMENT

Printed Patient Name: _____

Patient Date of Birth: _____

SS #: _____

Patient Signature: _____

I understand that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas Board of Medical Examiners



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