RODONAIA
FAMILY MEDICINE
+ AETHETICS

PHONE **409.554.8311** FAX **409.554.8312** EMAIL **INFO@RODOMD.COM**
2180 EASTEX FREEWAY, SUITE C - UPSTAIRS
BEAUMONT, TX 77703

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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NAME: _____ 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 409-554-8311 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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NAME: _____ DATE: _____

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:

Name: Rodonaia Family Medicine & Aesthetics

Address: 2180 Eastex Freeway, Suite C
Beaumont, Texas 77703

Records requested from:

Name: _____

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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