

Southwest Health Associates, P.A.

1229 Creek Way Dr. Suite 101
Sugar Land, TX 77478
PH: (281) 980-2100
FX: (281) 980-2170

Date: _____

Name: _____ Age: _____
Last First Middle

Address: _____
Street City State Zip

Date of Birth: _____ Male Female Martial Status: _____

Home Phone: _____ Cell Phone: _____ Driver's License: _____

Employer: _____ Occupation: _____

Employer Address: _____ Bus. Phone: _____

Your Soc. Sec. #: _____ Spouses Soc. Sec. #: _____

Name of Spouse/Parent: _____ Occupation: _____

Nearest Relative Not Living With You: _____
Full Name Address Phone

Have you had any serious illness in the past? No Yes Describe _____

Have you had any surgeries in the past? No Yes Describe _____

List all the medications you are presently taking: _____

List all the medications you are allergic to: _____

Do you smoke? No Yes is yes, how much? _____

Do you drink? No Yes is yes, how much? _____

Briefly state your purpose for medical attention today: _____

How will you be paying today? Cash Check Charge Other

Health Insurance: _____ Phone: _____

Policy #: _____ Group #: _____

Insured Person: _____ Relationship to Patient: _____

How did you hear about us? _____

I authorize Southwest Health Associates, P.A. to treat me and assign any medical insurance benefits to Southwest Health Associates, P.A. and also agree to be responsible for all unpaid bills.

Signature of Patient