Yi Zhou, M.D. & Jiaxin Lu, M.D.
6360 Corporate Dr. Suite B
Houston, TX 77036
Phone: 713-981-8898
Fax: 713-271-9859
Text: 832-836-7627

Welcome to the clinic of Yi Zhou, M.D. & Jiaxin Lu, M.D.

Date: ____ Gender: _______________________________

Name: _______________________________________ Date of Birth: __________________________
Last Name First Name

Social Security Number:_________________________ Marital Status: _________________________

Address: ____

Home Phone:__________________________________ Cell: (______) ________________________

Emergency Contact:_____________________________ Phone: (______) ________________________

Spouse Name:_________________________________ Phone: (______) ________________________

Employer: ____________________________________ Address: ______________________________

Primary Insurance Company: _____________________ Policy Number: _________________________

Name of Insured:_______________________________ Group Number: _________________________

Social Security Number of Spouse (or Parent if the insurance is through them): ____________________

Secondary Insurance: ____________________________

Your Email Address for Web Enabling Access________________________________

How did you hear about our clinic? ____

I authorize that my health insurance company to pay Dr. Zhou Family Medicine for my medical service.

Signature: ____ Date: _____________________________
(Parental signature if patient is under 18 years old)

I understand that I am financially responsible for all charges for services I receive, including the balance remaining after payment of possible benefits

Signature: ____ Date: _____________________________
(Parental signature if patient is under 18 years old)

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Name: ________________________________ Gender: ___________ Date of Birth: _______________

Chief Complaint / Reason for Visit: ____

Date of last general physical exam: ____

List of medication and food allergies: ____

List of medications and dosages you are taking: ____

____

List of medical problems: ____

List of past medical history: ____

List of surgical history: ____

List of family medical history: ____

Are you seeing the doctor because of an accident (Circle One)? Yes / No

Smoking History (Circle One): Never Smoker / Former Smoker / Current Smoker

Alcohol Use History (Circle One): Yes / No If yes, how much do you drink? ________________

All ages, please list the DATE and MANUFACTURER of COVID vaccines you have received:

Dose 1:_____________Dose 2:_____________Dose 3:_____________Dose 4:_____________Other__

If you are age 50 or above:

When was your colonoscopy? __________________________________Results: ___________________

Female Only : When was your last pap smear? ____________________Results: ___________________

When was your last mammogram? _________________Results: ___________________

If you are age 65 and above:

1) When was your last flu shot? ____

2) When was your last pneumonia vaccine (Pneumovax)? _______________________________

3) When was your last shingles vaccine? ____

4) When was your last eye exam by an eye doctor? _____________________________________

5) When was your last DEXA Bone Scan? ____

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Acknowledgement of Review
Privacy Practices

I, the undersigned, have reviewed the Privacy Practices, which explains that all of my personal and medical information are private and protected, and how my medical information will be used and disclosed.

I understand that I am entitled to receive a copy of the Privacy Practices.

本人（签名人）已经审查了《隐私惯例》，该条例解释说我的所有个人和医疗信息都是私有的并 且受到保护，以及我的医疗信息将如何使用和披露。

我了解我有权收到《隐私惯例》的副本。

Signature of Patient or Representative （签名） Date（日期）

Print Name of Patient or Representative （拼写你的名字）

Capacity of Personal Representative: Parent, Guardian, Trustee, Executor （个人代表关系）

Address: Street, City, State, Zip （地址）

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Name: ________________________Date of Birth: __________________Date: ___________

Vitals Information

Height: _______________________(Ft/Inches)

Weight: _______________________(Lbs)

Blood Pressure: ________________(mmHg)

Heart Rate: ____________________(Beats per minute)

Temperature: __________________(F/C)

Your Preferred Pharmacy Information for Prescriptions

Name of Pharmacy: ____

Pharmacy Address: ____

Pharmacy Phone #: ____

Please remember to call or walk in to our clinic within one week to follow up results of ALL blood work and imaging tests (normal and abnormal).

Signature: _________________________________Date: __________________

Thank you for choosing Dr. Zhou & Dr. Lu