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? _____

Female Only : When was your last pap smear? _____Results: _____

When was your last mammogram? _____Results: _____

If you are age 45 or above:

When was your colonoscopy? _____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