



Bainbridge Integrated Healthcare

Elizabeth Emeri, MSN, APRN, PMHNP-BC · Dr. Norbert Emeri, APRN, FNP-CNP, DNP
5373 W Alabama St, Ste 204 Houston, TX 77056
Phone: (281) 909-6124 Fax: (281) 767-2583

PATIENT INFORMATION

First Name: _____ MI: ____ Last Name: _____

Date of Birth: _____ SSN: _____

Home Telephone: _____ Cell Telephone: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

May we leave a message for you at home? Yes No

May we leave a message for you at work? Yes No

Sex: Male Female

Marital Status: Single Married Widowed Divorced

Emergency Contact: _____

Relationship: _____

Emergency Phone #: _____

Patient Employer or School (if student): _____

PRIMARY INSURANCE INFORMATION

Primary Insurance Name: _____

Claim Address: _____

City: _____ State: _____ Zip: _____

Group Number: _____

Policy ID Number: _____



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Subscriber Name: _____

Relationship to Patient: _____

SECONDARY INSURANCE INFORMATION (if applicable)

Secondary Insurance Name: _____

Subscriber Name: _____

Policy / Group Number: _____

Marital Status: S M W D

If married, spouse's name: _____

Previous Physician: _____

Current Physician (if any): _____

Preferred Pharmacy: _____

ALLERGIES TO MEDICATIONS, X-RAY DYES, OR OTHER SUBSTANCES

No Yes

If yes, list medication/substance and reaction:



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PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

(Please check all that apply)

- High Blood Pressure
- Diabetes
- Cancer
- Chest Pain
- Shortness of Breath
- Asthma
- Bronchitis
- Pneumonia
- Tuberculosis
- Thyroid Disease
- Kidney Disease
- Liver Disease
- Ulcers
- Acid Reflux / GERD
- Change in Bowel Habits
- Gallbladder Disease
- Hepatitis / Jaundice
- Anxiety
- Depression
- Alcohol Abuse
- Drug Abuse
- Seizures
- Stroke
- Arthritis
- Gout
- Skin Disorders
- Other (list): _____



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CURRENT MEDICATIONS AND DOSAGE

SURGICAL HISTORY (List all surgeries and year)

WOMEN ONLY

Age at first menstrual period: _____

Periods: Regular Irregular

Still having periods? Yes No

Date of last period: _____

Pregnancies: ____ Births: ____

Miscarriages: ____ Abortions: ____

History of abnormal Pap smear? Yes No

Last Mammogram: _____

PATIENT SIGNATURE

I certify that the above information is true and complete to the best of my knowledge.

Patient Signature: _____

Date: _____