Bainbridge Integrated Healthcare

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: _____

Subscriber Name: _____

Relationship to Patient: _____

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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:

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

(Please check all that apply)

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☐ 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): _____

CURRENT MEDICATIONS AND DOSAGE

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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: _____