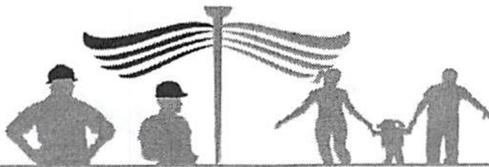

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WE ACCEPT CASH, VISA OR MASTERCARD

PATIENT INFORMATION:

NAME: ______________________________

DATE OF BIRTH : ____________________

ADDRESS: ______________________________

CITY: ________________ STATE: ____________ ZIP: __________

SSN : # ____________________

TELEPHONE NUMBERS: email: ______________________________

HOME: ______________________________

CELL: ______________________________

EMPLOYMENT STATUS: [ ] FULL-TIME [ ] PART-TIME [ ] STUDENT
[ ] RETIRED [ ] UN-EMPLOYED [ ] HOUSEWIFE

MARITAL STATUS: [ ] SINGLE [ ] MARRIED [ ] DIVORCED
[ ] SEPARATED [ ] WIDOWED

RACE: [ ] NATIVE AMERICAN [ ] ASIAN [ ] WHITE [ ] AFRICAN-AMERICAN
[ ] UNKNOWN [ ] REFUSE TO REPORT [ ] OTHER: ____________

ETHNICITY: [ ] HISPANIC/LATINO [ ] NOT HISPANIC/LATINO
[ ] REFUSE TO REPORT [ ] UNKNOWN

LANGUAGE: [ ] ENGLISH [ ] SPANISH [ ] OTHER: ____________________

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:

I AUTHORIZE TREATMENT AND AGREE TO PAY ALL FEES AND CHARGES FOR THE PERSON NAME ABOVE. I AGREE TO PAY ALL CHARGES SHOWN BY STATEMENTS, PROMPTLY UPON THEIR PRESENTATION, UNLESS CREDIT ARRANGEMENTS ARE AGREED UPON IN WRITING.

X______________________________ **DATE:** ____________________

13601 Woodforest Blvd. Houston, TX 77015 | **Phone:** 713-330-4325 | **Fax:** 713-330-1910
Website: www.drjanki.com | **E-mail:** drjanki@drjanki.com

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HEALTH AND HISTORY

ILLNESS/ INJURIES : PLEASE CHECK IF YOU HAVE EVER HAD OR IF PRESENT IN THE FAMILY:

ILLNESS/INJURIY	YES	NO	ILLNESS/INJURY	YES	NO	IF YES, EXPLAIN:
HIGH BLOOD PRESSURE			STD'S			
DIABETES			YELLOW JAUNDICE			
FAINTING SPELLS			HEPATITIS			
PEPTIC ULCERS/ BLEEDING			KIDNEY STONES			
HEART ATTACK/ MURMURS			LUNG PROBLEMS			
CHEST PAIN/ TIGHTNESS			STOMACH PROBLEMS			
SHORTNESS OF BREATH			THYROID PROBLEMS			
STROKE			CHILDHOOD DISEASE			
CANCER			BACK/ JOINT/ LIGAMENT			
ANEMIA			BROKEN BONES			
SKIN ALLERGY/ REACTION			ANY DISABILITY			
GALLSTONES			ASTHMA			
DEPRESSION/ ANXIETY			LOSS OF FINGERS/ LIMB			

ALLERGIES TO DRUGS:

____

____

____

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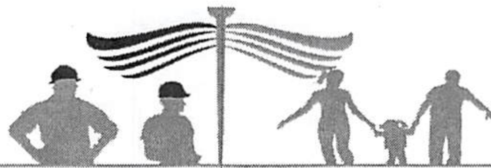

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PERSONAL HABITS/ RISK FACTORS:

HABIT/ RISK FACTORS	YES	NO	
IS YOUR JOB A RISK TO YOUR HEALTH?			EXPLAIN:
ARE YOU MARRIED?			STATUS:
ARE YOU AND YOUR PARTNER MONOGAMOUS (NO OTHER SEX PARTNERS)			
RECENT TRAVEL?			TO WHERE?
DO YOU EXERCISE?			WHAT TYPE:

FEMALES ONLY:

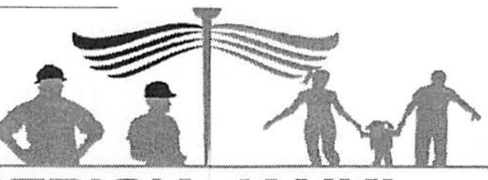
ARE YOU PREGNANT: YES NO	HOW MANY CHILDREN HAVE YOU DELIVERED?
DATE OF LAST MENSTRUAL PERIOD:	IS YOUR CYCLE REGULAR? YES NO

THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE, OR GUARDIAN IF PATIENT IS A MINOR:

X: ______________________________

DATE: ______________________________



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IMMIGRATION EXAMINATION

EXTRA INFORMATION TO COMPLETE THE IMMIGRATION FORM.

ALL INFORMATION MUST BE WRITTEN CORRECTLY AND PLEASE USE PRINT.

FIRST NAME: ______________________________

MIDDLE NAME: ______________________________

LAST NAME: ______________________________

PLACE OF BIRTH: ______________________________

COUNTRY OF BIRTH: ______________________________

A-NUMBER (IF ANY): ______________________________

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