Said Bina, M.D.
11850 FM 1960 Houston, Texas 77065

Tele: (281)469-0596 Fax: (281)807-9480

Referring physician:_____

Patient Information:

Patient Name:_____ Spouse Name:_____

DOB:_____ Age:_____ Sex:_____ Social Security Number:_____

Address:_____
City State Zip Code

Home Phone:(___)_____ Work Phone:(____)_____

Emplyer:_____

Address:_____

PLEASE COMPLETE IF THE PERSON RESPONSIBLE FOR BILL IS OTHER THAN THE ABOVEPATIENT

Name:_____ Relationship to patient:_____

Home Phone:(___)_____DOB_____ Social Security Number:_____

Employer:_____ Work Phone:(___)_____

Address:_____
City State Zip code

Emergency Contact

In Case of Emergency Please contact:_____

Health Insurance Information

Name of Insurance:_____ Phone:(___)_____

Policy Holder:_____ Relationship to Patient:_____

Policy Number:_____ Group Number:_____

Medicare Number:_____ Medicaid Number:_____

Authorization and Consent of the Medical Treatment of a Minor:

Parent or Guardian Signature:_____ Relationship:_____

Patient Agreement:

I authorize payment of medical insurance benefits to Said Bina M.D.,P.A .F.A.C.S. and release of any medical or other information necessary to process any claim filed for benefits.

I understand that payment is expected at the time services are rendered according to the provisions of my insurance plan. I accept full financial responsibility for any such fees incurred.

Signature:_____ Date:_____

Patient Medical History

Are you ***ALLERGIC*** to any medications? YES_____ NO_____

List_____

_____

List of Current medications and the dosage, if available?_____

_____

_____

_____

Are you taking any ***ASPIRIN*** or any aspirin related medications or ***ANTICOGULATS/BLOOD THINNERS*** or ***HEART*** related medications? YES_____ NO_____

List_____

_____

Have you had any ***SURGERY***? Yes_____ NO_____ If so, please list them,

_____

_____

_____

Past or Present Illnesses: Please explain any answers you checked;

____Heart Disease_____

____High Blood Pressure_____

____Pace Maker_____

____Mitral Valve Prolapse_____

___Rheumatic Fever_____

___Nerves_____

___Hepatitis_____

___Diabetes_____

___Bleeding Tendency_____

___Scaring Tendency_____

___Hormonal_____

Do you or have you ever had any of the following? If so please explain,

___Yes ___No Smoking_____

___Yes ___No Alcohol or Alcoholism _____

___Yes ___No Fainting from Injections _____

___Yes ___No Any reaction to local anesthesia _____

___Yes ___No Any risk factor for HIV or AIDS _____

___Yes ___No Have you ever had a blood transfusion _____