NASRULLAH MANJI, M.D.

PATIENT INFORMATION

Please check one: ☐ New Patient ☐ Updated Info

NAME	SOCIAL SECURITY NO.	MARITAL STATUS (S M D W)	SEX (M F)	BIRTHDATE

ADDRESS	CITY, STATE, ZIP	HOME PHONE	DRIVERS LICENSE

EMERGENCY CONTACT *(Phone Number)*

PTS EMP	EMPLOYER'S ADDRESS *(Include City, State, and Zip)*	WORK PHONE	OCCUPATION

PRIMARY CARE PHYSICIAN	PATIENT CELL NUMBER	PART ☐ FULL ☐ TIME

RESPONSIBLE PARTY / GUARANTOR INFORMATION

(Complete this section only if patient is NOT responsible for this account)

	SEX	PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY (Spouse / Child / Other)	BIRTHDATE

ADDRESS	CITY, STATE, ZIP	HOME PHONE	SOCIAL SECURITY NO.

EMPLOYER	EMPLOYER'S ADDRESS *(Include City, State, and Zip)*	WORK PHONE

INSURANCE INFORMATION

(Please present insurance cards to Receptionist IN ADDITION to completing the area below)

INSURANCE: COMPANY NAME	IDENTIFICATION NUMBER	GROUP NUMBER

INSURANCE COMPANY ADDRESS

NAME OF POLICY HOLDER	DATE OF BIRTH	PATIENT'S RELATIONSHIP TO POLICYHOLDE

ADDITIONAL INSURANCE: COMPANY NAME	IDENTIFICATION NUMBER	GROUP NUMBER

INSURANCE COMPANY ADDRESS

NAME OF POLICY HOLDER	DATE OF BIRTH	PATIENT'S RELATIONSHIP TO POLICYHOLDE

MEDICAID NUMBER

ADDITIONAL INFORMATION

☐ YES ☐ NO WERE YOU INJURED ON THE JOB? DATE_____

☐ YES ☐ NO WERE YOU INJURED IN AN AUTOMOBILE ACCIDENT? DATE_____

WHEN DID YOU FIRST CONSULT US FOR THIS CONDITION? DATE_____

I consent to treatment as necessary or desirable for the care of the patient first named above, including but not restricted to whatever drug medicine and conduct of laboratory, Xray, or other studies that may be used by the attending physician or his nurse or qualified designate.

I acknowledge full responsibility for the payment of such services and agree to pay for them in full at the time of service, unless oth arrangements are made in advance.

I request that payment of authorized insurance benefits be made on my behalf to the provider indicated above for any services furnished m I authorize any holder of medical information about me or my dependents to release to the insurance company any information needed determine these benefits or the benefits payable for related services. A photocopy of this assignment is to be considered as valid as t original until revoked. I understand that I am financially responsible for all charges whether or not covered by said insurance, and agree promptly pay any balance remaining after insurance payment. I authorize the provider to initiate a complaint to the Insurance Commissior for any reason on my behalf.

Phone: (281) 491-9300 **Fax: (281) 491-9391**

Nasrullah Manji, M.D., P.A.

Diplomate of the American Board of Internal Medicine
And Gastroenterology

As a courtesy to you, we will be happy to file an insurance claim form to your insurance company on your behalf. Any co-payments are due at the time of your visit to the office. We will be happy to assist you in any way possible if there is a problem receiving payment from your insurance company.

Charges are incurred are ultimately your responsibility not your insurance company. We strive to file all claims in a timely manner. It is your responsibility, as the insured, to contact your insurance company regarding any delay or discrepancy with payment. Any balance left on your account is due and payable within thirty days. If payment in full is not possible, we will be happy to assist you're with satisfactory arrangements to pay the balance of your account.
We want your visit to our office to be a pleasant one. Please do not hesitate to ask for assistance with any questions or concerns.

The office staff of Nasrullah Manji M.D.P.A.

Patient Signature: _____ Date Signed: _____

For any test that you may have, you will need to make a two-week follow-up appointment to get your test results. Dr. Manji will not give results over the phone.

Patient Signature: _____ Date Signed: _____

Acknowledgement of Receipt of Notice of Privacy Practices:

I have read the copy of this office's Notice of Privacy Practices. (Attached to clipboard).
If you would like a copy please ask the front desk for your personal copy

Patient Signature: _____ Date Signed: _____

What contact phone number may we leave messages on to contact you: _____

PLEASE READ & SIGN THE SECTION BELOW ONLY IF YOU HAVE AN HMO INSURANCE

It is your responsibility to make sure the requirements of your plan have been met, which includes a written referral from your primary care physician, which is due at the time of your appointment. If your plan requirements are not followed, you will be financially responsible for all or part of the services rendered in the office. Charges incurred are ultimately your responsibility not your insurance company.

Also, all premiums for your insurance company need to be up to date and current on the day of your services. If you are in a grace period we will not be able to see you until the insurance company can verify that your premium has been paid for the current month.

Patient Signature: _____ Date Signed: _____

4760 Sweetwater Blvd.
Suite 101
Sugar Land, Texas 77479

12121 Richmond Ave.
Suite 224
Houston, Texas 77082

NASRULLAH MANJI MDPA

Name: _____ **Date of Visit:** _____

Do you smoke?	Yes	No	**No. of yrs.**	**How much per day?**
Do you drink alcohol?	Yes	No	**How many ounces/beers per day?**	
Are you under a lot of pressure at work?	Yes	No		
Hepatitis Risk Factors:	Blood transfusion prior to 1992		Tattoos	Body Piercings
Do you have an allergy to the contrast/dye for CT Scans?	YES	NO	If YES explain:	

CHIEF COMPLAINT: (Main Reason For Visit) CHECK ONLY WHAT APPLIES TO YOU

_____ Abdominal Pain	_____ Constipation	_____ Poor Appetite
_____ Abnormal Liver Enzymes	_____ Diarrhea	_____ Rectal Bleeding
_____ Anemia	_____ GERD	_____ Swallowing Difficulty
_____ Blood in Stool	_____ Hepatitis B	_____ Weight Gain
_____ Change in Bowel Habits	_____ Hepatitis C	_____ Weight Loss
_____ Colon Screening	_____ Nausea or Vomiting	_____ Other: _____

FAMILY HISTORY: CHECK ALL THAT APPLY

	If So Who?		If So Who?
_____ Colon Cancer	_____	_____ Renal Cancer	_____
_____ Colon Polyps	_____	_____ Liver Disease	_____
_____ Stomach Cancer	_____	_____ Hemachromatosis	_____
_____ Colitis/ Crohn's Disease	_____	_____ Gall Bladder Disease	_____

REVIEW OF SYSTEMS - PLEASE CHECK ALL THAT APPLY TO YOU

_____ Abdominal Pain	_____ Diabetes	_____ Kidney Stones
_____ Anal Fissure	_____ Diverticulitis	_____ Loss of Control of Bowels
_____ Anxiety / Depression	_____ Dysphagia	_____ Mucous In Stool
_____ Arthritis	_____ Fatigue	_____ Nausea / Vomiting
_____ Asthma	_____ Feeling of Fullness	_____ Osteoporosis / Osteopenia
_____ Atrial Fibrillation	_____ Fever/Chills	_____ Painful Swallowing
_____ Bloating/Gas	_____ Fluid in Abdomen	_____ Pancreatitis
_____ Blood In Stool	_____ Gallstones	_____ Prostate Cancer/Enlarged
_____ Blood On Toilet Paper	_____ GI Bleed	_____ Rectal Bleeding
_____ Chest Pain,Pressure, Angina	_____ Heartburn / Reflux	_____ Renal Failure/Insufficiency
_____ Cirrhosis of the Liver	_____ Hepatitis A,B,C other	_____ Sleep Apnea
_____ Colon Polyps	_____ High Blood Pressure	_____ Swelling of Feet or Legs
_____ Congestive Heart Failure	_____ High Cholesterol	_____ Thyroid Problems
_____ Coronary Artery Disease / Angina	_____ H. Pylori	_____ Ulcerative Colitis
_____ Crohn's Disease	_____ Irregular Bowel Habits	_____ Unexpected Weight Loss/Gain
_____ Decreased Appetite	_____ Jaundice	_____ Urinary Tract Infections

ATTENTION PATIENTS: PLEASE FILL OUT THIS FORM ONLY IF YOU ARE CURRENTLY TAKING ANY MEDICATIONS.

PATIENT NAME: _____

				DATE OF OFFICE VISIT					
	MEDICATIONS	***MG***	***DOSE***						
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

DRUG ALLERGIES:

Nasrullah Manji M.D.P.A.
4760 Sweetwater Blvd. # 101
Sugar Land, Tx. 77479
Office: (281)-491-9300 Fax: (281)-491-9391

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This takes effect (04-14-03), and will remain in effect until we replace it.
We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.
You may request a copy of your notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for a service we provided to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.
To Your Family and Friends: We must disclose your health information to you, as described in the Patients Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your locations, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Requires by Law: We may use or disclose your health information when we are required to do so by law.