KRISTE BABBITT, M.D., PLLC
4550 Post Oak Place Drive, Suite 320 * Houston, TX 77027 * (713) 622-5480

PATIENT INFORMATION

This office utilizes an electronic health record. Please complete the information below to enable us to communicate with you according to our necessity and your preferences.

Name: _____ DOB: _____

Social Security Number: _____-_____-_____ Today's Date: _____

Address: _____

City: _____ Zip Code: _____

Telephone Communications

Please only leave contact information for phone numbers where you would be willing to accept an incoming call from our office.

Mobile Phone: (_____)_____

Home Phone: (_____)_____ Work Phone: (_____)_____

Electronic Communications

Please only provide your email address if you are willing to accept electronic communications from our office.

Email address (print carefully): _____

Would you like appointment reminder alerts sent to your email address above? **Y** **N**

- *Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.*
- *No one can diagnose your condition from email or other written communications, and communication via our website cannot replace the relationship you have with a physician or another healthcare practitioner.*
- *Emails are checked during business hours only. If you have a matter that requires urgent attention after hours or on weekends, please call.*
- *Communications via our portal are encrypted and automatically become a part of your electronic health record.*
- *Communications via gmail or other non-portal text are not encrypted, but are still considered part of your health record.*
- *Any text or email initiated by yourself is an implicit consent to receive electronic communications from our office within the same medium (i.e. sending an email to Dr. Babbitt's gmail account implies agreement to receive a reply via gmail).*

I have read, understood, and agree to the above guidelines on electronic communications.

Signature: _____ Date: _____

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Late Cancellations, Missed Appointments, and Source of Payment

YOU WILL BE CHARGED FOR MISSED APPOINTMENTS UNLESS YOU PROVIDE 24-HOUR NOTICE. PLEASE NOTE THAT INSURANCE WILL NOT REIMBURSE FOR MISSED APPOINTMENTS. BY SIGNING, YOU AGREE THAT ALL CHARGES ARE YOUR RESPONSIBILITY AND THAT FILING FOR OUT-OF-NETWORK INSURANCE REIMBURSEMENT IS YOUR RESPONSIBILITY IF YOU CHOOSE TO DO SO.

Signature of Guarantor: _____ Date: _____

Guarantor Name: _____ Relationship to Patient: _____

If different from patient information above:

Address: _____ Zip: _____

Cell No: (_____)_____ Business No: (_____)_____

Home No: (_____)_____

Emergency Communications

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: (_____)_____

Preferred Pharmacy Information

Pharmacy Name: _____

Address: _____ Zip: _____

Phone: (_____)_____ Fax: (_____)_____

Demographic and Clinical Information

Employer: _____ Occupation: _____

Education: _____ Religion: _____

Marital Status: single married domestic partnership separated divorced widowed

Name of Spouse/Partner (if not listed as emergency contact above): _____

Spouse/Partner Occupation: _____ Phone: (_____)_____

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Please list all individuals living in your household (including minors/children).

Name	Relationship	Age	Occupation

Please list all family members not living in your present household (including parents, siblings, children, separated/divorced partners).

Name	Relationship	Age	Occupation

How were you referred? _____

Please briefly describe the problem or situation that has led you to seek treatment:

_____

_____

Have you experienced this problem before? If so, when and what treatment did you receive?

_____

_____

Do you have any particular treatments in mind? If so, what? _____

_____

Name of primary/family doctor: _____

Name(s) of other current treating provider(s): _____

_____

_____

Other concerns/information: _____

_____

_____