SAI Medical Care
800 Bonaventure Way Unit 128
Sugar Land, Texas 77479
Phone: 832-532-0370
Fax: 832-440-1343

Suman Ravuri MD PA

New Patient Intake Form

Please fill in all information as accurately as possible

Patient Information

Patient Name:_____ Date of Birth: ____/_____/_____ Sex: M / F / Other:_____
Address: _____
(Street) (City/State/Zip)
Home Phone: (____) _____-_____ E-Mail Address: _____
Cell Phone: (____) _____-_____ (Circle One) Married/Single/Divorced/Widow

Who to call for an emergency:
Name: _____ Address: _____
Cell Phone: (____) _____-_____ Relationship: _____

Insurance Information

Primary Insurance
Plan Name: _____ I.D. Number:_____
Group Name: _____ Policy Holder Name: _____
Policy Holder's Date of Birth: _____ Effective Date: _____
Policy Holder's Social Security Number: ____- ____-____
Patent Relationship to Policy Holder:_____
Secondary Insurance (*If applicable*)
Plan Name: _____ I.D. Number:_____
Group Name: _____ Policy Holder Name: _____
Policy Holder's Date of Birth: _____ Effective Date: _____
Policy Holder's Social Security Number: ____- ____-____
Patent Relationship to Policy Holder:_____

Additional Information

Have you been fully vaccinated for COVID-19? ___ One dose ___ Both dose ___ Booster Vaccine ___ None

Have you received your flu vaccine for 2021? ____ Yes ____ No ____ Would like one today? Yes or No *(please circle)*

If you fall under the criteria of hypertension and hyperlipidemia, would you like to hear more information about obtaining a free blood pressure monitor device? YES ☐ NO ☐

Preferred Pharmacy (*If any changes)*
Pharmacy Name:_____ Pharmacy Address or Phone Number:_____

Family or Other Physician Involved in your care:
Physician's Name: _____ Specialty: _____
Physician's Address: _____ Physician's Number: _____
(Please use space below to list other physician's involved in your care if applicable)

Patient initial: _____

Back copy as well

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Medical Intake Information

Allergies

- ☐ No known Allergies
- ☐ No known drug Allergies

If any allergies please list below:

_____

_____

Current Medications

- ☐ No known medications
- ☐ I take the following prescription below (*Please include dose and how often)*

_____

_____

_____

_____

_____

Smoking Status

- ☐ Never smoker
- ☐ Former smoker
- ☐ Current every day smoker
- ☐ Current some day smoker

If current or former smoker how many packs and how long?

_____

Hospitalization or Surgery

- ☐ No hospitalizations
- ☐ No Surgery

If any Hospitalizations or Surgeries please list below in detail and with a date:

_____

_____

_____

Alcohol Status

- ☐ Do not drink
- ☐ Drink daily
- ☐ Socially drink
- ☐ Hx of Alcoholism
- ☐ Occasional drink

Medical History

- ☐ Hypertension
- ☐ Heart Attack
- ☐ Hypothyroidism
- ☐ Asthma
- ☐ Pneumonia
- ☐ Ulcer or GI disorder
- ☐ Diabetes Type 1 or 2
- ☐ Arthritis
- ☐ Sexual/menstrual dysfunction
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Depression
- ☐ Heart disease
- ☐ Cancer
- ☐ Other _____

Family History

Mother's Parents	Father's Parents	Mother	Father	
☐ -	☐ -	☐ -	☐ -	Alive
☐ -	☐ -	☐ -	☐ -	Deceased
☐ -	☐ -	☐ -	☐ -	No Health Concern
☐ -	☐ -	☐ -	☐ -	Heart Disease
☐ -	☐ -	☐ -	☐ -	Heart Attack
☐ -	☐ -	☐ -	☐ -	Stroke
☐ -	☐ -	☐ -	☐ -	High Cholesterol
☐ -	☐ -	☐ -	☐ -	Cancer
☐ -	☐ -	☐ -	☐ -	Diabetes Type 1 or 2
☐ -	☐ -	☐ -	☐ -	Kidney Disease
☐ -	☐ -	☐ -	☐ -	Osteoporosis
☐ -	☐ -	☐ -	☐ -	Thyroid Disease
☐ -	☐ -	☐ -	☐ -	Bleeding Disorder
☐ -	☐ -	☐ -	☐ -	Epilepsy/Convulsion
☐ -	☐ -	☐ -	☐ -	Asthma
☐ -	☐ -	☐ -	☐ -	Multiple Sclerosis
☐ -	☐ -	☐ -	☐ -	Alzheimer's

_____

Please list any others not mentioned above

Patient signature: _____