Farzana Sahi, M.D.
7777 Southwest Freeway, Ste 640 Houston, TX 77074
Phone:(713)270-0477 Fax:(713)270-1655

PATIENT INFORMATION

LAST NAME: **FIRST NAME:**

MIDDLE NAME: **MALE** **FEMALE**

DATE OF BIRTH
(mm/dd/yyyy)

COMPLETE HOME ADDRESS:

A #(IF AVAILABLE) **USCIS ACC #**

EMAIL:

HOME PHONE: **CELL PHONE:**

CITY OF BIRTH: **COUNTRY OF BIRTH:**

(MARK ONLY IF FEMALE) ARE YOU CURRENTLY PREGNANT? **YES** **NO**

AUTHORIZATION FOR TREATMENT

I grant permission to Dr. Farzana Sahi and her medical staff to perform any and all medical/surgical procedures necessary for the diagnosis and treatment of my medical condition.

E Sign: **Date:**

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MRZ MEDICAL

IMMIGRATION MEDICAL HISTORY

Any medical conditions/allergies we should be aware of? If yes, please explain.
Have you ever had a positive Tuberculosis test? If yes, please place the year and the test that was performed. (Example: X-ray, blood test or PPD Skin Test)
Have you ever had a positive STD test? If yes, please give us the name of the disease and if you were treated.
Have you been diagnosed with a physical or mental disorder? If yes, please explain your condition and if you are being treated for it.
Have you ever had a drug or alcohol addiction? If yes, please explain when and what type of treatment you had.