Leonel Reyes, M.D.

427 9th Street

San Antonio, Texas 78215

210-227-1289

Today's Date______________

Name____ ☐ Male ☐ Female

If Minor Name Of Guardian____

Date Of Birth ___________________ SSN#______-_____-______ ID/DL ________________

Address____

City____State_______________ZIP___________

Home# (_____)_______________Wk#(_____)______________ Cell #(_____)______________

E-mail: ____

REFERRED BY:_________________________________

Are you allergic to any medications? _____No ____Yes

Please list and give type of reaction to the medication: ______________________________

____

**************************************PLEASE COMPLETE***********************************

Primary Care Physician: ____

Address____Phone (_____)____________

Person To Be Contacted In An Emergency Or If You Cannot Be Located:

(Preferably someone not living in same house)

Name____Phone(____)________________

Address____Phone #2 (_____)_____________

Relationship____

Please note: Any controversy, claim or dispute that involves Leonel Rey, MD or any independent provider associated with Sun Research Institute, L.L.C. shall be settled by mediation or arbitration in accordance with the rules of the American Arbitration Association, and judgement upon the award rendered by the arbitrators may be entered in any court have jurisdiction thereof.

____ ________________________

Signature Date

NAME OF PATIENT____

Current Medical Conditions And Start Dates. Include Any Allergies.

1. ________________________________ **4.** ____________________________________

2. ________________________________ **5.** ____________________________________

3. ________________________________ **6.** ____________________________________

7. ________________________________ **8.** ____________________________________

9. ________________________________ **10.** ___________________________________

11. _______________________________ **12.** ___________________________________

Surgeries and hospitalizations and dates if known:

1. ________________________________ **4.** ____________________________________

2. ________________________________ **5.** ____________________________________

3. ________________________________ **6.** ____________________________________

Medications record:

(Include birth control pills, sleeping aids, vitamins, any OTC medications, etc)

Medication & dose	Reason for taking	Date Started

I acknowledge that I have accurately and thoroughly completed this form.

____ ____________________

Signature of Patient **Date**