



Patient Registration

If this is a Workman's Compensation claim please notify at check-in

Name _____ Gender _____

Address _____ City _____ State _____ ZIP _____

Home phone _____ Work _____ Cell _____

Date of birth _____ Age _____ Social Security # _____ Marital S M D W

Employer _____ Occupation _____

Emergency Contact _____ Phone _____

Please provide us with your local pharmacy:

Name _____ Phone _____

Primary Care Physician _____ Phone _____ Referred by _____

Primary Insurance _____ Secondary _____

Policy Holder Information (if different from the patient)

Name _____ Relationship to patient _____ Gender M F

Address _____ City _____ State _____ ZIP _____

Home phone _____ Work _____ Cell _____

Date of birth _____ Age _____ Social Security # _____

Employer _____ Occupation _____

Employer address _____

Please indicate whether the information above is for the primary insurance or secondary.

The health insurance information provided above is complete. I have no other health care coverage.

I give permission to Surgical Group of North Texas, L. L. P. or any of the staff to release any information regarding my medical records or billing records to the following person or persons:

Signature _____ Date _____

Surgical Group

of North Texas

Name: _____

Date: _____

Review of Systems (Current Issues)

Constitutional

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weakness | <input type="checkbox"/> Marked weight loss | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Persistent fever | <input type="checkbox"/> Sensitive to heat/cold | <input type="checkbox"/> Marked weight gain | |

Eyes

- | | | | |
|--|------------------------------------|--|--|
| <input type="checkbox"/> Temporary visual loss | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Wear glasses/contacts | |
|--|------------------------------------|--|--|

Ears, Nose, Mouth, Throat

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Dentures | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Loss of smell | |

Breasts

- | | | | |
|---------------------------------------|---|--|--|
| <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Nipple discharge | <input type="checkbox"/> Breast tenderness | |
|---------------------------------------|---|--|--|

Heart

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Rapid heart rate | <input type="checkbox"/> Skipped beats |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Leg pain with walking | <input type="checkbox"/> Leg swelling | |

Lungs

- | | | | |
|---|--|--|-----------------------------------|
| <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Blood in sputum | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Productive cough | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis | |

Musculoskeletal

- | | | | |
|--|---------------------------------------|--|---|
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Knee pain | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Elbow pain |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Wrist pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Joint swelling |
| <input type="checkbox"/> Muscle cramps | <input type="checkbox"/> Disc disease | | |

Gastrointestinal

- | | | | |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Reflux | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Vomiting blood | <input type="checkbox"/> Ulcer disease | |

Genitourinary

- | | | | |
|--|---|--|------------------------------------|
| <input type="checkbox"/> Stress incontinence | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Discharge |
| <input type="checkbox"/> Frequent urination at night | <input type="checkbox"/> Kidney failure | | |

Gynecologic

- | | | | |
|--|--|--|-----------------------------------|
| <input type="checkbox"/> Taking hormones | <input type="checkbox"/> Heavy periods | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Fibroids |
| <input type="checkbox"/> Pelvic infections | <input type="checkbox"/> Painful intercourse | <input type="checkbox"/> Ovarian cysts | |

Skin

- | | | | |
|------------------------------------|---|--|-------------------------------|
| <input type="checkbox"/> Hair loss | <input type="checkbox"/> Change in mole | <input type="checkbox"/> Change in nails | <input type="checkbox"/> Rash |
|------------------------------------|---|--|-------------------------------|

Endocrine

- | | | | |
|---|-----------------------------------|---------------------------------|--|
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Goiter | |
|---|-----------------------------------|---------------------------------|--|

Neurologic

- | | | | |
|---|--------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Seizures | <input type="checkbox"/> Passing out | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Poor balance |
| <input type="checkbox"/> Parkinsonism | <input type="checkbox"/> Memory loss | | |

Surgical Group of North Texas

Name: _____ Birthdate: _____ Sex: _____ Date: _____

Please state the reason for coming to the doctor today. _____

HAVE YOU HAD SURGERY BEFORE TODAY (Please check or list all that apply)

- | | | | |
|--|---------------------------------------|---|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Breast Biopsy | <input type="checkbox"/> Hernia Left Right Umbilical |
| <input type="checkbox"/> Breast Cancer Surgery | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Coronary Artery Bypass | <input type="checkbox"/> Removal of Ovary Left Right |
| <input type="checkbox"/> Any Other Surgery _____ | | | |

DO YOU HAVE ANY MEDICAL PROBLEMS (Please check or list all that apply)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Dialysis |
| <input type="checkbox"/> Reflux | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Blood Clotting Problems | <input type="checkbox"/> Irregular Heart | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Other _____ |
-
-

DO YOU TAKE ANY MEDICATIONS (Please check or list all that apply)

- | | | | |
|-----------------------------------|----------------------------------|---------------------------------|--|
| <input type="checkbox"/> Coumadin | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Plavix | <input type="checkbox"/> Any Other Medications |
|-----------------------------------|----------------------------------|---------------------------------|--|
-
-
-
-
-

DO YOU HAVE ANY ALLERGIES OR ILL EFFECTS FROM MEDICATION (Please list any)

SOCIAL HISTORY

- | | | |
|---|---|--|
| <input type="checkbox"/> Tobacco Use Yes No _____ packs/day _____ years | <input type="checkbox"/> Married | <input type="checkbox"/> Divorced |
| <input type="checkbox"/> Alcohol Use Yes No _____ drinks/day | <input type="checkbox"/> Widowed | <input type="checkbox"/> Single |
| <input type="checkbox"/> Other Drug Use | <input type="checkbox"/> Premenopausal | <input type="checkbox"/> Age at first childbirth _____ |
| <input type="checkbox"/> Type of Employment _____ | <input type="checkbox"/> Postmenopausal | <input type="checkbox"/> Age at first period _____ |

ARE THERE MEDICAL PROBLEMS IN YOUR FAMILY (Please check or list all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Ovarian Cancer | <input type="checkbox"/> Other Cancers | <input type="checkbox"/> Other Diseases |
-
-
-



Edward Clifford, MD, FACS

Sina Matin, MD, FACS

Julio Rivera, MD, FACS

Shahid Shafi, MD, FACS

NOTICE OF PRIVACY PRACTICES

For _____

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

As a health care provider we are legally obligated to maintain the privacy of your health information, provide you with this "Notice of Privacy Practices" and to abide by these terms.

We may disclose medical records and other identifiable health information for your treatment, payment or health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. This includes coordination of care with a third party, consultation between health care providers, or referral to another provider.
- Payment means activities undertaken to obtain payment for services, including determination of eligibility and benefits, pre-certification or pre-authorization of services, billing and collections.
- Health care operations refers to business aspects of running our practice such as quality assessment and improvement activities.

We may contact you with appointment reminders or to provide information about health related benefits or services that may be available to you.

We will not use or disclose protected health information for any other purposes without obtaining your authorization. Any authorization may also be revoked.

You have the following rights regarding your health information upon written request:

- The right to request restrictions on certain uses and disclosures.
- The right to receive confidential communications of your protected health information.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to obtain a record of disclosures of protected health information.

There are circumstances in which we are not required to agree with your request to restrict the use and disclosure of your information or to amend your protected health information.

We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

If you have any concerns or suspect any violations of privacy rights you may contact the privacy supervisor or office manager at (972) 254-9399. No retaliation will be taken against an individual who files a complaint. Complaints may also be filed with the secretary of the department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201. However, we would prefer to be contacted so that we can ratify any issues as they arise.

Effective Date: April 14, 2005

1600 W. College St., Ste. LL10 • Grapevine, TX 76051
P. 817.251.0070 F. 972.259.2040

2001 N. MacArthur Blvd., Ste. 255 • Irving, TX 75061
P. 972.254.9399 F. 972.259.2040



Edward Clifford, MD, FACS

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Julio Rivera, MD, FACS

Shahid Shafi, MD, FACS

OUR FINANCIAL POLICY

Dear _____

Thank you for choosing us as your health care provider. Our main concern is that you receive the proper and optional treatments needed to restore your health.

We ask that all patients read and sign our financial policy as well as complete our patient information form prior to seeing the doctor. If you have any questions or concerns about our payment policies, please do not hesitate to ask our office staff.

Your co-payment is due at the time services are rendered. We accept cash, checks, and for your convenience, Mastercard and Visa cards.

As a courtesy to you, we will be happy to file your insurance claim for reimbursement as long as you bring your insurance card with all information. It is your responsibility to provide us with correct, up-to-date insurance information. However, you must understand that:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company. We will do all we can to assist you but it is your insurance policy. It is your responsibility to understand your health care network and which physicians and health care facilities you may use.
2. Not all services are covered benefits in all contracts. Those not covered will be your responsibility. Please check your insurance plan.
3. Co-payments and unpaid deductible are due at the time of treatment.
4. You may pay your balance due with cash, check, Mastercard or Visa.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Again, thank you for choosing us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

Patient's Signature

Date

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CONSENT

I, _____, consent to the use and disclosure of protected health information for the purposes of treatment, payment and health care operations by Drs. Clifford, Matin, Rivera, and Shafi (Surgical Group of North Texas, L.L.P.). I may review the notice of privacy practices for additional information regarding use and disclosure.

I understand that the terms of the privacy practices may change and that I may request a copy of the notice at any time during normal business hours.

I understand that I may request restrictions on uses and disclosure of my information. I also understand that Surgical Group of North Texas, L. L. P. is not required to agree with those requests; but if in agreement, is required to honor those requests.

This consent may be revoked by submitting a written request to Surgical Group of North Texas, L. L. P. This revocation does not affect any use or disclosure that has already occurred.

I have received a copy of the "Notice of Privacy Practices."

Signature

Date

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