1056 Texan Trail
Grapevine, Texas 76051
Main 817 251 0070
Phone 972 254 9399

PATIENT REGISTRATION

(If this is a Workman's Compensation claim, please notify us at check in.)

Office Use Only- Chart #________________________

This form must be completed before seeing the Doctor to ensure accurate records for your medical file and secure payment from your insurance company. Payment arrangements must be made at time of service.

Patient's Last Name ________________________ First Name __________________________ Middle Initial _____

Social Security # ___________________________ Race ____________________ Marital S ❒ M ❒ D ❒ W ❒

Gender M ❒ F ❒ Transgender M ❒ F ❒ Date of Birth ________________________ Age__________

Address __________________________________ City ____________________ State _________ ZIP _________

Home Phone _____________________________ Work ____________________ Cell ________________________

Email Address ____

How did you hear about us? ______________ Which Provider are you here to see? _________________

Emergency Contact Information

Name __________________________________ Relationship ______________ Phone ____________________

Policy Holder Information (if different from the patient)

Policy Holder / Subscriber Name _______________________________________ Date of Birth _____________

Relationship to Patient ______________________ Social Security # _____________________ Gender M ❒ F ❒

Address __________________________________ City _____________________ State ________ ZIP _________

Please indicate whether the information above is for the ❒ primary or ❒ secondary insurance. The health insurance information provided above is complete. I have no other health care coverage. ________Initial

Primary Care Physician Name ____ Phone _________________

Referred by ❒ Physician ❒ Friend ❒ Website Website Address ______________________________

Referring Physician's Name _____________________________ Phone _______________________________

Employment Information

Employer ____ Occupation ___________________________

Address ____ Phone ________________________________

Pharmacy Information

Name ____ Phone ________________________________

I give permission to Surgical Group of North Texas, LLP and any of the staff to release any information regarding my medical records or billing records to the following individual / individuals:

____

Signature ____ Date _________________________________

Surgical Group of North Texas

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Grapevine, Texas 76051
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Phone 972 254 9399

MEDICAL HISTORY

Last Name ______________________ First Name ______________________ Middle Initial ________

Gender M ❒ F ❒ Transgender M ❒ F ❒ Age: _____ Date of Birth: ______________ Marital S ❒ M ❒ D ❒ W ❒

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

____

HAVE YOU HAD SURGERY BEFORE TODAY? (Please check all that apply and **include year**.)

❒ Appendectomy ______________ ❒ Hernia: ❒ Left ❒ Right ❒ Umbilical ______________

❒ Breast Biopsy ______________ ❒ Hysterectomy ______________

❒ Breast Cancer Surgery ______________ ❒ Open Abdominal Surgery ______________

❒ Coronary Artery Bypass ______________ ❒ Removal of Ovary: ❒ Left ❒ Right ______________

❒ Gallbladder ______________ ❒ Other ______________

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

❒ Diabetes ❒ Type I ❒ Type II ❒ Asthma ❒ Lung Cancer ❒ High Blood Pressure

❒ Emphysema ❒ Stroke ❒ Kidney Problems ❒ Dialysis

❒ Reflux ❒ Liver Problems ❒ Stomach Ulcer ❒ Heart Disease

❒ Blood Clotting Problems ❒ Irregular Heart ❒ Congestive Heart Failure ❒ Thyroid Disease

❒ High Cholesterol ❒ Other ______________________________

** **WHEN WAS THE LAST TIME YOU HAD THE FOLLOWING?** **

Year of Last Pap Smear: ______________ Year of Last Mammogram: ______________

Year of Last Colonoscopy: ______________ Year of Last Flu Vaccine: ______________

Year of Last Pneumonia Vaccine: ______________ Any recent travel to Caribbean, Central America or South America?

❒ Yes ❒ No

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MEDICAL HISTORY

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Gender M ❒ F ❒ Transgender M ❒ F ❒ Age: _____ Date of Birth: ______________ Marital S ❒ M ❒ D ❒ W ❒

DO YOU TAKE ANY MEDICATIONS? (Please **check or list** all that apply.) ❒ Yes ❒ No
If yes, please list below which medications, dosage and frequency taken.

❒ Aspirin (81 mg or 325 mg) ❒ Coumadin ❒ Effient ❒ Eliquis

❒ Plavix ❒ Pradaxa ❒ Other Blood Thinners

MEDICATION LIST

1. ______________ 4. ______________ 7. ______________
2. ______________ 5. ______________ 8. ______________
3. ______________ 6. ______________ 9. ______________
10. ______________

**** DO YOU HAVE ANY ALLERGIES OR ILL EFFECTS FROM MEDICATION? **** ❒ Yes ❒ No (Please list below)

____
____
____

SOCIAL HISTORY

Tobacco Use ❒ Former ❒ Never ❒ Yes ______ packs/day _____ years ❒ Other Drug Use ______________

Alcohol Use ❒ Former ❒ Never ❒ Yes ______ drinks/day ______________

Age of First Period ________ Age of First Childbirth ______________ ❒ Premenopausal ❒ Postmenopausal

ARE THERE MEDICAL PROBLEMS IN YOUR FAMILY (**within the first degree - example: parents, siblings children**)**?** (Please check all that apply and specify relationship.)

❒ Arthritis ______________ ❒ High Blood Pressure ______________

❒ Breast Cancer ______________ ❒ Lung Disease ______________

❒ Colon Cancer ______________ ❒ Ovarian Cancer ______________

❒ Diabetes ______________ ❒ Prostate Cancer ______________

❒ Heart Disease ______________ ❒ Stroke ______________

❒ Other Cancers ______________ ❒ Other Diseases ______________

Revised 12 / 2017

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REVIEW OF SYSTEMS

Last Name ______________________ First Name ______________________ Middle Initial ________

Gender M ❒ F ❒ Transgender M ❒ F ❒ Age: _____ Date of Birth: ______________ Marital S ❒ M ❒ D ❒ W ❒

HAVE YOU EXPERIENCED ANY OF THESE SYMPTOMS RECENTLY? (Please check all that apply.)

CONSTITUTIONAL

❒ Chills ❒ Fatigue ❒ Lethargy ❒ Persistent Fever
❒ Weakness ❒ Weight Loss

EARS, NOSE, MOUTH, THROAT

❒ Ear Drainage ❒ Hoarseness ❒ Loss of Hearing ❒ Mouth Pain
❒ Nasal Congestion ❒ Nose Bleeds ❒ Sinus Problems ❒ Sore Throat
❒ Throat Swelling ❒ Tongue Pain / Swelling ❒ Toothache ❒ Voice Changes

ENDOCRINE

❒ Cold Tolerance ❒ Heat Tolerance ❒ Increased Thirst ❒ Increased Urine
❒ Thyroid Dysfunction ❒ Weight Gain ❒ Weight Loss

GASTROINTESTINAL

❒ Abdominal Pain ❒ Anorexia ❒ Blood in Stool ❒ Constipation
❒ Diarrhea ❒ Painful Swallowing ❒ Rectal Pain ❒ Reflex
❒ Vomiting Blood

GENITOURINARY

❒ Blood in Urine ❒ Frequent Urination ❒ Painful Urination ❒ Testicular Pain
❒ Testicular Swelling ❒ Urgent Urination ❒ Urinating at Night

HEART

❒ Chest Pain or Discomfort ❒ Inability to Lie Flat ❒ Leg Swelling ❒ Palpitations
❒ Shortness of Breath on Exertion

LUNGS

❒ Coughing up Blood ❒ Non Productive Cough ❒ Pain with Breathing ❒ Pneumonia
❒ Productive Cough ❒ Shortness of Breath ❒ Wheezing

MUSCULOSKELETAL

❒ Arthritis ❒ Back Pain ❒ Extremity Swelling ❒ Joint Pain
❒ Joint Swelling ❒ Muscle Pain ❒ Neck Pain

NEUROLOGIC

❒ Bladder Problems ❒ Bowel Problems ❒ Confusion ❒ Fainting
❒ Headaches ❒ Lightheadedness ❒ Numbness ❒ Problems Walking
❒ Seizure ❒ Vision Changes ❒ Weakness

PSYCHOLOGIC

❒ Agitation ❒ Anxiety ❒ Confusion ❒ Depression
❒ Hallucinations ❒ Insomnia ❒ Stress

SKIN

❒ Abrasion ❒ Bruising ❒ Itching ❒ Lacerations
❒ Rashes

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NOTICE OF PRIVACY PRACTICES

Last Name ______________________________ First Name _________________________ Middle Initial _________

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

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OUR FINANCIAL POLICY

Last Name ______________________________ First Name_________________________ Middle Initial _________

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 polices, 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.

____________________________________ ____________________________________
Signature Date

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CONSENT

Last Name ________________________ First Name ____________________ Middle Initial ________

I,________________________, consent to the use and disclosure of protected health information for the purposes of treatment, payment and health care operations by Drs. Alibhai, Clifford, Emerson, Matin, Rivera, Shafi and Schierling (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