Surgical Group of North Texas

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

1056 Texan Trail
Grapevine, Texas 76051
Main 817 251 0070
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

Revised 2 /2019

Surgical Group of North Texas

1056 Texan Trail
Grapevine, Texas 76051
Main 817 251 0070
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 ❒

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 7. _____

MEDICATION LIST

1. _____ 4. _____ 8. _____

2. _____ 5. _____ 9. _____

3. _____ 6. _____ 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 _____

Surgical Group of North Texas

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

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 ❒ Reflux
❒ 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

Surgical Group of North Texas

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

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

Surgical Group of North Texas

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

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

Surgical Group of North Texas

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

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, 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