Please tell us how you heard about us.
Referring Physician name: ______
Radio ☐ TV ☐ Pamphlet ☐ Search Engine ☐
Other, *Please specify*: ______

PATIENT INFORMATION

Date: ______ ☐New Patient ☐Update
Patient: ______
Last First MI Preferred Title
☐Male ☐Female ☐Child* ☐Student** ☐Single ☐Married ☐Divorced ☐Widowed

*If Child, provide parent/guardian name(s) below:
______
Parent/Guardian Name(s)

**If Student, please complete: ☐Full-time ☐Part-Time
______
School/Location

Patient Date of Birth: ______ Patient SSN: ______
Address: ______
Address Line 1
______
Address Line 2
______
City ST Zip Code
E-Mail: ______
Home: ______
Cell: ______
Other: ______
Pager: ______
Fax: ______
Referral? ☐Yes ☐ No Referred by: ______

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person

______ Tel: ______
Name Relationship

EMPLOYMENT INFORMATION

Employer: ______ Occupation: ______
Address: ______
Address Line 1
______
Address Line 2
______
City ST Zip Code
E-Mail: ______
Work: ______ Ext: ______
Direct: ______
Other: ______
Pager: ______
Fax: ______

INSURANCE INFORMATION

Insured: ______
Last First MI Preferred Title
Insured's Date of Birth: ______ Insured's SSN: ______
Insured Employer: ______
Patient Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other

Primary Insurance Carrier: ______
Group/Policy No.: ______ ID No.: ______
Address: ______
______
______
City ST Zip Code
Tel: ______
Toll-free: ______
Fax: ______

Secondary Insurance Carrier: ______
Group/Policy No.: ______ ID No.: ______
Address: ______
______
______
City ST Zip Code
Tel: ______
Toll-free: ______
Fax: ______

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PREVIOUS PHYSICIAN INFORMATION

Provider: ________________ Telephone: ________________

Clinic/Facility: ________________

Address: ________________

____
CITY ST ZIP CODE

Reason for changing: ________________

PRIMARY PHYSICIAN INFORMATION

Physician: ________________ Telephone: ________________

Clinic/Facility: ________________

MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Under a physician's care now?
☐Y☐N Any hospitalization in the past 5 years? ________________
☐Y☐N Any serious illnesses/surgeries? ________________
☐Y☐N Use tobacco in any form? If Yes, Type: ________________
☐Y☐N Is pre-medication required before medical visits due to heart condition or artificial joint?
☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, please explain in the Medication Section.*

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date: ________________

Do you know of any reason why routine medical procedures might pose a risk to you, our staff, or other patients? ☐Y☐N
If yes, please describe:

____

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

____

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ACID REFLUX
☐ADHD
☐AIDS/HIV
☐ANEMIA
☐ANOREXIA
☐ANXIETY
☐ARTIFICIAL HEART VALVE
☐ARTIFICIAL JOINTS
☐ARTHRITIS
☐ASTHMA
☐AUTISM/ASPERGER'S
☐BLEEDING DISORDER
☐BULIMIA
☐CANCER/MALIGNANCY
☐CEREBRAL PALSY
☐CHEMICAL DEPENDENCY
☐CHICKEN POX
☐CONVULSIONS
☐DEPRESSION
☐DIABETES
☐DIZZINESS/FAINTING
☐EPILEPSY/SEIZURES
☐FREQUENT EAR INFECTIONS
☐ FREQUENT HEADACHES
☐HEARING PROBLEMS
☐HEART ATTACK
☐HEART DISEASE
☐HEART MURMUR
☐HEPATITIS
☐HIGH BLOOD PRESSURE
☐KIDNEY DISEASE
☐LIVER PROBLEMS
☐MITRAL VALVE PROLAPSE
☐MONONUCLEOSIS
☐PACEMAKER
☐OTHER – PLEASE LIST: ________________
☐PSYCHIATRIC TREATMENT
☐RADIATION/CHEMO
☐RESPIRATORY DISEASE
☐RHEUMATIC FEVER
☐SINUS PROBLEMS
☐STROKE
☐THYROID CONDITION
☐TUBERCULOSIS
☐ULCERS
☐VENEREAL DISEASE

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ASPIRIN
☐ANESTHETIC – LOCAL
☐BARBITURATES
☐OTHER – PLEASE LIST: ________________
☐CODEINE
☐DAIRY
☐LATEX
☐LACTOSE INTOLERANCE
☐METAL SENSITIVITY
☐NITROUS OXIDE SEDATION
☐SLEEPING PILLS
☐SULFA DRUGS
☐PENICILLIN/OTHER ANTIBIOTICS

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MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ NONE

☐ ANTIBIOTICS/SULFA DRUGS	☐ ANTIHISTAMINES/ALLERGY	☐ DAILY ASPIRIN	☐ BLOOD PRESSURE MEDICATIONS
☐ BLOOD THINNERS	☐ CANCER/CHEMO MEDICATIONS	☐ CORTISONE/STEROIDS	☐ HEART MEDICATION/DIGITALIS
☐ INSULIN	☐ NITROGLYCERIN	☐ ORAL CONTRACEPTIVES	☐ OSTEOPOROSIS MEDICATIONS
☐ OTHER DIABETIC MEDICATIONS	☐ RECREATIONAL DRUGS	☐ THYROID MEDICATIONS	☐ TRANQUILIZERS
☐ OTHER (PLEASE LIST BELOW)			

DRUG NAME	DOSAGE	REASON PRESCRIBED

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Financial Guidelines

We are committed to providing you with the best care possible. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept all major insurance payers and plans, however we may not be an in network provider for your plan. If we are not an in network provider, *please* review your plan details.

- **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.

- **Workers Compensation claims** will be filed for you. Please understand the carrier will assign a dollar amount that will be paid towards the claim, which may or may not cover the entire fee. Any amount not covered by the carrier, will be your responsibility.

- **Minors must be accompanied by a parent or legal guardian**. If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.

Payments

- **Patient portion or patient co-pay is due at the time services are rendered** - unless prior financial arrangements have been made.

- **Payment Information:**
  - All major credit cards are accepted (Visa, MasterCard, Amex, Discover)
  - Please ask for us for uninsured pricing discount
  - We also have payment plan option available on our website (www.dallasmedphysicians.com) through the ePAY function.

Short Cancelled/ Missed Appointments

- **Please give 48 hours notice** if you are unable to keep your scheduled appointment. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you.

By signing below I acknowledge I have read and understand the guidelines above.

Signature: ______________________________ Date: ________________

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my provider's Patient Information Privacy Policy containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of the Patient Information Privacy Policy. I understand that my provider has the right to change the Patient Information Privacy Policy and that I may contact our office to obtain a current copy of the Patient Information Privacy Policy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: ______________________________ **Date:** ______________

RELATIONSHIP TO PATIENT: ☐ADULT PATIENT ☐PARENT ☐GUARDIAN ☐ OTHER ______________

Please list any dependent children under the age of 18 also covered by this acknowledgement:

____

____

____

☐ I give permission for the following communications to be used by my provider. **(please check all that apply)** :
☐ Cell Phone ☐Text Message Reminders ☐ Home Phone ☐ Work ☐ E-Mail:

☐ I am granting permission for my provider to disclose their identity to anyone who may answer my home, work or cell phone.

☐ I am granting permission for my provider to leave a call back message with any person who may answer my phone or on my voicemail of the following numbers **(please check all that apply)**:
☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ None- please just ask for a call back

☐ Other (Please explain) ______________________________

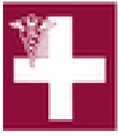
I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:

____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ The patient refused to sign
☐ Communication barriers
☐ Emergency situation
☐ Other – please list: ______________________________



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PATIENT CONSENT- PAYMENT AUTHORIZATION – SIGNATURE ON FILE

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the doctor and staff at the next appointment without fail.

I hereby authorize payment directly to the Dallas Medical Physician Group of the benefits otherwise payable to me.

I hereby authorize the Dallas Medical Physician Group to release any information concerning my health care, advice, treatment or supplies provided. This information is to be used in administering claims and/or discussing treatment options with other medical professionals.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature: ______________________________ Date: ____________________