NTMC
North Texas
Medical Center

Patient Demographics

PATIENT INFORMATION SHEET

Patient's Full Name: _____ **Social Security #:** ____-____-____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Birthdate: ____/____/____ **Age:** _____ **Sex: M / F**

Follow My Health will give you access to your records online. Would you like to sign up? YES / NO

Email: _____

MARITAL STATUS (*CIRCLE ONE*)**: SINGLE / MARRIED / DIVORCED / WIDOWED**

Phone Number (HOME): _____ **(CELL):** _____

Employer: _____ **(WORK #):** _____

RACE: CAUCASIAN / AFRICAN-AMERICAN / OTHER / REFUSE

LANGUAGE: ENGLISH / SPANISH / OTHER / REFUSE

ETHNICITY: HISPANIC/ NON-HISPANIC / OTHER / REFUSE

Spouse/Parent/Guardian: _____ **Birthdate:** ____/____/____

Phone Number (HOME): _____ **(CELL):** _____

EMERGENCY CONTACT: _____ **Phone #:** _____

Primary/Referring Physician: _____

****Please list names of persons authorized to obtain your medical information:** (*Ex: spouse, children, etc.*)

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have been given the opportunity to review this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand than I am entitled to receive a copy of this document.

X _____ ____/____/____

Signature of Patient or Personal Representative **Date**

_____

Witness

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PATIENT INFORMATION SHEET

DO YOU HAVE ANY FOOD/DRUG ALLERGIES? YES / NO Please list:

****PLEASE LIST ALL PREVIOUS SURGERIES:**

PHARMACY:

PLEASE LIST *ALL* CURRENT MEDICATIONS YOU ARE TAKING:

DO YOU TAKE ASPIRIN? YES / NO DOSAGE: 81 / 325 MG

IS THERE ANY FAMILY HISTORY OF: ***Diabetes:*** **YES / NO** ***Cancer:*** **YES / NO**
Heart Disease: **YES / NO** ***Other:*** **YES / NO**

ARE YOU PREGNANT? **YES / NO WHEN WAS YOUR LAST MENSTRUAL PERIOD?**

Have you had ANY of the following problems?	**Please circle YES or NO**		
Heart disease, heart murmur, heart attack, congestive heart failure	YES / NO	Blood disease, leukemia, or lymphoma	YES / NO
High blood pressure, Blood clots	YES / NO	Kidney disease, prostate problems, urinary infections	YES / NO
Liver disease, yellow jaundice, hepatitis	YES / NO	Gallbladder disease	YES / NO
Lung disease, asthma, COPD, emphysema, sleep apnea	YES / NO	Bowel problems, constipation, IBS, diarrhea	YES / NO
Stomach disease, ulcers, bloating, heartburn	YES / NO	Unexplained weight loss	YES / NO
Blood in stools	YES / NO	Thyroid problems	YES / NO
Diabetes	YES / NO	Tumors, growths, skin lesions	YES / NO
Seizures, convulsions, stroke	YES / NO	Have you ever taken steroids?	YES / NO
Anesthesia problems	YES / NO	Have you ever been seriously ill?	YES / NO
Do you have or have you had a drug or alcohol problem?	YES / NO	Do you smoke? (If YES, how many packs/day?) _____	YES / NO

X _____
Signature of Patient or Personal Representative

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NTMC
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Medical Center

SURGICAL SPECIALISTS OF NORTH TEXAS
FINANCIAL POLICY

Patient Demographics

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your successful treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

All patients must complete our information and insurance form before seeing the doctor.

- FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA/MASTERCARD OR DISCOVER.

INSURANCE

We are participants in the Medicare and Medicaid programs. Please be aware that some services provided may be non-covered and not considered reasonable and necessary under these programs. In such cases, the patient is responsible for the charges.

I understand that in the event of an overpayment on the account, any refund due will be refunded to the appropriate party, except as follows: it is hospital policy to apply any credit balance that may exist as a result of this hospital stay to any other accounts for myself or a member of my family for whom I am legally responsible. In the event there are no other accounts, a prompt refund will be made.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MINOR PATIENTS

A parent or guardian must accompany a minor before non-emergency treatment can be administered.

I have read the Financial Policy, I understand and agree to the conditions of the Policy.

Signature of Patient or Responsible Party _____ **Date** _____