NTMC
North Texas
Medical Center

Patient Information

Patient Demographics

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

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____/_____/_____ 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: _____ Date of Birth: _____/_____/_____

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 that I am entitled to receive a copy of this document.

X _____ Date: _____/_____/_____
Signature of Patient or Personal Representative

X _____
Witness

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Patient Medical History

Patient Demographics

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 DOSE: 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, 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
Convulsions	YES / NO	Have you ever taken any steroids?	YES / NO
Anesthesia problems	YES / NO	Have you ever been seriously ill?	YES / NO
Do you have or have had any drug or alcohol problems?	YES / NO	Do you smoke? (If yes, how many packs/daily?) _____	YES / NO

X _____

Signature of Patient or Personal Representative

NEW PATIENT

QUESTIONS	YES	NO
HYSTERECTOMY?	TOTAL PARTIAL (ABD) RADICAL (VAG)	
HOW MANY PREGNANCIES?		
DRUG OR FOOD ALLERGIES? REACTIONS:		
HAVE YOU EVER USED TOBACCO?	HOW MUCH? WHEN DID YOU QUIT?	
ALCOHOL CONSUMPTION?	QUANTITY AND FREQUENCY:	
HAVE YOU EVER USED DRUGS?	WHAT KIND: IF NOT CURRENTLY USE, WHEN DID YOU QUIT?	
DIABETES IN THE FAMILY?	WHO? MOTHER OR FATHER SIDE?	
HEART DISEASE?	WHO? MOTHER OR FATHER SIDE?	
CANCER? WHO AND WHAT KIND OF CANCER?	SELF: MOTHER: FATHER: SISTER: BROTHER: MOTHER SIDE FATHER SIDE GRANDMOTHER: GRANDFATHER: AUNT: UNCLE: COUSIN:	

NTMC
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Surgical Specialist 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 for your bill is considered 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 payments 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 participate in the Medicare and Medicaid programs. Please be aware that some services provided may be non-covered and not considered reasonable and/or 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 the hospital policy to apply any credit balance that may exist as a result of this hospital stay or 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 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.

X _____ Date: _____/_____/_____

Signature of Patient or Personal Representative