Gary W. White, M.D. Dean A. Cione, M.D. Jeremy S. Carrasco, M.D. Ramsey A. Stone, M.D

6124 W. Parker Rd., Suite 436, Plano, TX 75093 Phone: 972-608-3356 / Fax: 972-608-3360

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PATIENT REGISTRATION FORM

First Name: ________________________ MI:_____ Last Name: __________________________ Date of Birth: ___________

Address:____________________________________ Apt#:________ City: _______________ State:________ Zip: _________

Home Phone: (____) __________________ Cell Phone: (____) __________________ Work Phone (____) _________________

SS#: ____ - ____ - ____ SEX: ☐ Female ☐ Male E-mail Address:____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Preferred Language: _____________________________

Race: ☐ American Indian and Alaska Native ☐ Bi-Racial ☐ Middle Eastern ☐ Hawaiian/Pacific Islander ☐ White/Caucasian
☐ Black or African American ☐ Other ☐ Unknown

Employed: Y / N PT / FT Employer: _________________________________ Address:_______________________________

Marital Status: S M D W Sep SO Spouse Name: _________________________________ Phone: (____) _______________

Emergency Contact Name: _________________________ Relationship: ______________ Phone: (____) _______________

If the Patient is **NOT** the Subscriber (person who carries insurance) please provide additional information requested below:

Primary Insurance: _________________________________

Identification Number: _________________________ Group Number: ________________ Phone Number: __ _______________

Subscriber Name: __________________________________ DOB: ________________ Relationship: ___________________

Employed: Y / N PT / FT Subscriber Employer Name: _____________________________

Secondary Insurance: ______________________________

Identification Number: _________________________ Group Number: ________________ Phone Number: _________________

Subscriber Name: __________________________________ DOB: ________________ Relationship: ___________________

Is this Worker's Compensation? Yes No Date of Injury: __________________ Claim#: ___________________________

Primary Care Physician: ____ Phone: (____) _______________

Referring Physician: (if applicable) ____ Phone: (____) _______________

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CONSENT TO TREAT ASSIGNMENT OF BENEFITS

CONSENT TO TREAT: I, the undersigned, hereby consent to and authorize all diagnostic and therapeutic treatment performed at our locations considered necessary or advisable in the judgment of the physician.
ASSIGNEMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private or group insurance, or other health plans to our offices.
RELEASE OF MEDICAL INFORMATION: I hereby give permission for our offices to release my medical information pertaining to the care I receive from this office to my insurance company if so requested in order to achieve payment.
FINANCIAL RESPONSIBLILTY: I accept ultimate financial responsibility for all charges incurred with our offices whether paid by insurance or not.

Patient's Signature: ____ Date: _______________
(Guarantor's Signature if under 18 years of age)

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MEDICAL HISTORY

NAME: ____ TODAY'S DATE: ________________

REASON FOR VISIT: ____

AGE _________________ HEIGHT _____________________ WEIGHT _ ___________________

PRIMARY CARE DOCTOR: _________________________________ PHONE___________________________

LIST ANY MEDICATIONS YOU ARE TAKING, INCLUDING NON-PRESCRIPTION DRUGS, VITAMINS, AND HERBALS. (Use back if necessary) ____

____

____

DRUG ALLERGIES: ____

Are you currently taking or have you taken Fen/Phen, Redux, or any other weight reduction medication? YES NO

If yes, please explain ____

REVIEW OF SYSTEMS:

Do you have now or have had within the past year:

Fatigue	YES	NO	chest pain	YES	NO	excessive hunger	YES	NO
fever	YES	NO	rapid heart beat	YES	NO	difficulty walking	YES	NO
night sweats	YES	NO	leg pain when walking	YES	NO	depression	YES	NO
weight loss	YES	NO	abdominal pain	YES	NO	seizures	YES	NO
weight gain	YES	NO	blood in stool	YES	NO	rash	YES	NO
eye discharge	YES	NO	chg. in bowel habits	YES	NO	itchy skin	YES	NO
vision loss	YES	NO	constipation	YES	NO	change in moles	YES	NO
ear discharge	YES	NO	diarrhea	YES	NO	joint / bone pain	YES	NO
hearing loss	YES	NO	vomiting	YES	NO	muscle weakness	YES	NO
ringing in the ears	YES	NO	painful urination	YES	NO	easy bleeding	YES	NO
nasal drainage	YES	NO	excessive urination	YES	NO	easy bruising	YES	NO
difficulty swallowing	YES	NO	blood in urine	YES	NO	swollen lymph nodes	YES	NO
chronic cough	YES	NO	cold intolerance	YES	NO	environmental allergies	YES	NO
shortness of breath	YES	NO	heat intolerance	YES	NO	food allergies	YES	NO
wheezing	YES	NO	excessive thirst	YES	NO			

WOMEN ONLY:

Age Period Began ______ Number of Pregnancies _______ Live Births_______ Miscarriages/Abortions___________

Date of Last Mammogram _______________ Result ____

Do you do regular breast self-examinations? __________________________________

Have you ever had a breast lump or discharge?________________________________

Start date of last menstrual cycle (if applicable) ________________________________

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PAST MEDICAL HISTORY:

Have you ever had the following?

AIDS or HIV+	YES	NO	Tuberculosis	YES	NO	Radiation	YES	NO
Anemia	YES	NO	Glaucoma	YES	NO	Rheumatic Fever	YES	NO
Arthritis	YES	NO	Heart Disease	YES	NO	Stomach Ulcer	YES	NO
Asthma	YES	NO	Mitral Valve Prolapse	YES	NO	Stroke	YES	NO
Bleeding Tendency	YES	NO	High Blood Pressure	YES	NO	Thyroid Disease	YES	NO
Chemotherapy	YES	NO	Kidney Disease	YES	NO	Diabetes ↓	YES	NO
Cancer ↓	YES	NO	Hepatitis ↓	YES	NO	Type ___________		
Type ________________			Type _________________					

LIST PREVIOUS SURGERIES (Use back if necessary):

____

____

LIST MAJOR ILLNESSES/HOSPITALIZATIONS (Use back if necessary):

____

____

FAMILY HISTORY:

Has any blood relative ever had any of the following?

Diabetes	YES	NO	High Blood Pressure	YES	NO	Kidney Disease	YES	NO
Stroke	YES	NO	Heart Disease	YES	NO	Depression	YES	NO
Melanoma ↓	YES	NO	Breast Cancer ↓	YES	NO	Other Cancers ↓	YES	NO
Relative(s) ____________________			Relative(s) ____________________			Type & Relative(s)		
____________________			____________________			____________________________		
						____________________________		
						____________________________		

SOCIAL HISTORY:

Smoking YES NO Type: ________________ Packs Per Day: __________

If Former Smoker, Date Quit: ____________________

If you are a CURRENT Smoker have you ever tried to quit? YES NO Date:________________

Alcohol Use: None Occasional Moderate Excessive

Drug Use:____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Patient's Signature**:** ____ Date:____________________

(Guarantor's Signature if under 18 years of age)

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Authorization for Release of Medical Information:
I certify that I was made available a copy of the "Notice of Protected Health Information Practices". I hereby authorize this office to release any of my medical or incidental information, including billing information, that may be necessary for medical care or to process medical insurance claims.

I give permission to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friends(s).

Name: ___________________________ Relationship: _______________________ Phone: (____) _________________

Name: ___________________________ Relationship: _______________________ Phone: (____) _________________

I do not wish my information to be disclosed to any person. Initial: ___________________

Authorization to Mail, Call or E-Mail:
I certify that I understand the privacy risks of the mail, phone calls and emails. I hereby authorize a representative or my physician to mail, call or email me with communications regarding my healthcare, such as appointment reminders and/or medical information regarding patient care. I understand that I have the right to revoke consent for any and all of the above initialed items at any time in writing.

Initial: ___________________

I have completed this form with accurate information. I have read and understand my obligations and responsibilities. I acknowledge that I am fully responsible for supplying current insurance information, billing information and payment of any services not covered or approved by my insurance carrier.

____

Signature of Patient or Authorized Representative Date

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Summary of Policy

Effective February 1, 2007 our practice requires patients to provide a guarantee of payment for services rendered via credit/debit card information and authorization to charge for balances. Our practice will comply with all state and federal collection, privacy, and security standards and laws. Rest assured, we work diligently with you and your insurance company to ensure proper payment from the appropriate parties regarding any applicable copay, deductible, and coinsurance requirements. We only use this authorization for balances not covered by your insurance company.

Authorization

I hereby authorize my physician's business office to 1) charge my credit/debit card for the applicable balance due for services rendered, 2) maintain a copy of my card and drivers license. I understand that if my insurance company denies my claim for any reason and said claim remains outstanding beyond 45 days from the Date of Service, my card may be charged for the balance due. I understand I have the right to revoke this authorization in writing via letter, fax, or email.

Please use the RIGHT side boxes to fill in your information.

Today's Date:	
Name (as it appears on card):	
Credit/Debit Card Number: Visa, Mastercard, Discover, American Express	
Expiration (month/year):	
Card Statement Billing Address:	
Patient Name (if different):	
Card Owner Signature:	

Staff Representative Signature:	