Dean A. Cione, M.D. Jeremy S. Carrasco, M.D. Ramsey A. Stone, M.D. Cynthia Kwong, M.D.

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

2821 E. President George Bush Hwy, Suite 100 Richardson, TX 75082 Phone: 972-644-2797 / Fax: 972-234-9041

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: _____ 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: _____

Primary Care Physician _____ Phone (____) _____

ReferringPhysician (if applicable) _____Phone (____) _____

Cardiologist (if applicable) _____Phone (____) _____

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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.

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits, including 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 permit our offices to release my medical information about the care I receive from this office to my insurance company if so, requested to achieve payment.

FINANCIAL RESPONSIBILITY: I accept ultimate financial responsibility for all charges incurred with our offices whether paid by insurance or not.

Patient's Signature: _____ Date: _____

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 permit to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relatives (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:_____

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

Signature of Patient or Authorized Representative: _____Date:_____

Authorization to Mail, Call, or E-Mail:

I certify that I understand the privacy risks of 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 all the above items at any time in writing.,

Patient's Initials:_____

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MEDICAL HISTORY

NAME: _____ TODAY'S DATE: _____

REASON FOR VISIT: _____

AGE _____ HEIGHT _____ WEIGHT _____

PHARMACY NAME: _____ 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 _____ _____

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 heartbeat	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	change g. 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 (ues 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
Relatives: _____			Relatives: _____			Type & Relatives:		
_____			_____			_____		
						_____		

DATE OF LAST FLU SHOT_____

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

How many days have you had 5 or more drinks in the last year?_____

Drug Use:_____

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

*Patient's Signature:*_____*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:	