**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

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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 the 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: _____

**Referring Physician**: (if applicable) _____Phone (____) _____

**Cardiologist**: (if applicable) _____ Phone (____) _____

**Pharmacy Name**: _____Phone (____) _____

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**CONSENT TO TREAT**: I, the undersigned, hereby consent to and authorize all diagnostic and therapeutic treatments performed at our locations that are considered necessary or advisable by a physician.

**ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits, including significant 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 permit our offices to release my medical information pertaining to the care I receive from this office to my insurance company if 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 the purpose of 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 mail, phone calls, and emails. I hereby authorize a representative or my physician to contact me by mail, phone, or email with communications regarding my healthcare, including appointment reminders and medical information related to patient care. I understand that I have the right to revoke my consent for any of the above-initialed items at any time in writing.

**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 paying for any services not covered or approved by my insurance carrier.

Signature of Patient or Authorized Representative: _____Date:_____

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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 _____ _____

Do you have now, or have you 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 | 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 | and excessive thirst | | | | | |

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 |
| Relatives: _____ | | | Relatives: _____ | | | Type & Relatives: | | |
| _____ | | | _____ | | | _____ | | |
| | | | | | | _____ | | |
| | | | | | | _____ | | |

**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

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

Drug Use: _____

**I VERIFY 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:** | |