Dallas Medical Physician Group

How Did You Hear About Us? _____

New Patient? ☐ Update Only? ☐

PLEASE PRINT VERY CLEARLY

Thank you for your assistance.

■ Patient Information

Name (Last, First, Middle) _____ Today's Date _____

Birthdate _____ **Soc. Sec. #** _____ **Home Phone** _____

Email Address _____ Cell Phone _____

Address _____ Work Phone _____

City _____ **State** _____ **Zip** _____ **Sex:** ☐ M ☐ F ☐ Transgender

☐ Check if Minor (less than18) **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Referring Physician _____ Phone _____

Race _____ Ethnicity _____ Preferred Language _____

■ Primary Insurance

Insurance Company _____

Insurance ID # _____ **Group #** _____

Please enter the policyholder's information below. If you are the policyholder yourself, check this box ☐ and skip to the next section.

Policyholder's Name (Last, First, Middle) _____

Relationship to Patient _____ Soc. Sec. # _____ **Birthdate** _____

Address _____ **Home Phone** _____

Employer _____ **Work Phone** _____

■ Secondary Insurance *(If not applicable, please cross out section. If you have tertiary insurance, please ask the receptionist for another page.)*

Insurance Company _____

Insurance ID # _____ **Group #** _____

Please enter the policyholder's information below. If you are the policyholder yourself, check this box ☐ and skip to the next section.

Policyholder's Name (Last, First, Middle) _____

Relationship to Patient _____ Soc. Sec. # _____ **Birthdate** _____

Address _____ **Home Phone** _____

Employer _____ **Work Phone** _____

■ Assignment, Release, & Consent to Treatment

I hereby authorize payment directly to Dallas Medical Physician Group of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered for me or for my dependents. I authorize the doctors and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above. I certify that I am the patient or the parent/legal guardian of the patient, and I consent to the treatment necessary for the care of the patient indicated on this form.

Signature: _____ Date: _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): _____ Relationship to Patient: _____

Dallas Medical Physician Group

Patient Name: _____

■ Medical Information

Please state the reason(s) for your visit today: _____

_____

Primary Care Physician's Name _____ Phone _____

Emergency Contact Name _____ Realtionship to Patient _____

Emergency Phone Number _____

Are you ALLERGIC to or have you ever had any reaction ? (Please list all allergies)_____

_____

		Yes	No
1.	Are you currently under medical treatment?	☐	☐
	Please describe: _____		
	_____		
2.	Have you ever had any hospitalizations or operations?	☐	☐
	Please describe: _____		
	_____		
3.	Are you taking any medications?	☐	☐
	Please list: _____		
	_____		
4.	Do you use tobacco in any form?	☐	☐
5.	Do you drink alcohol?	☐	☐
6.	Do you use any illicit drugs?	☐	☐

		Yes	No
7.	Have you had any allergic reactions to the following?		
	Local Anesthetics (eg. Novocaine)	☐	☐
	Penicillin or other Antibiotics	☐	☐
	Sulfa Drugs	☐	☐
	Barbiturates (sleeping pills)	☐	☐
	Other Sedatives	☐	☐
	Iodine	☐	☐
	Aspirin	☐	☐
	Other	☐	☐
	Please describe: _____		
	_____		
8.	Women Only:		
	Do you have regular periods?	☐	☐
	Are you using birth control pills / patch / injection?	☐	☐
	Are you pregnant now?	☐	☐
	Have you ever been pregnant?	☐	☐
	Number of Pregnancies: _____		

Please indicate which of the following conditions/illnesses you have or have not had:

	Yes	No
Acid Reflux	☐	☐
ADHD	☐	☐
Anemia (low blood count)	☐	☐
Anorexia (no appetite)	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Back Problems	☐	☐
Bleeding Tendency	☐	☐
Blood Disease	☐	☐
Cancer	☐	☐
Chemical Dependency (drug addiction)	☐	☐
Chemotherapy	☐	☐
Chicken Pox	☐	☐
Chronic Fatigue Syndrome	☐	☐
Circulatory Problems	☐	☐
Congenital Heart Lesions	☐	☐
Cough – persistent or bloody	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Epilepsy	☐	☐
Frequent Ear Infections	☐	☐
Heart Murmur	☐	☐
Heart Disease	☐	☐
Hepatitis – Type ____	☐	☐
Hernia	☐	☐
Herpes	☐	☐
High Blood Pressure	☐	☐
HIV / AIDS	☐	☐
Jaundice	☐	☐
Kidney Disease	☐	☐
Latex Sensitivity	☐	☐
Liver Disease	☐	☐
Low Blood Pressure	☐	☐
Measles	☐	☐
Migraines	☐	☐
Mitral Valve Prolapse	☐	☐
Pacemaker	☐	☐
Pneumonia	☐	☐
Prostate Problem	☐	☐
Psychiatric Care	☐	☐
Respiratory Disease	☐	☐
Rheumatic Fever	☐	☐
Shortness of Breath	☐	☐
Sinus Trouble	☐	☐
Stroke	☐	☐
Thyroid Problems	☐	☐
Tonsillitis	☐	☐
Tuberculosis	☐	☐
Ulcer	☐	☐
Venereal Disease	☐	☐
Any Other Condition	☐	☐
Please Describe: _____		
_____		

Dallas Medical Physician Group

BILLING and COLLECTION POLICIES

Our goal is to provide you with high-quality and efficient care. There are many details involved in the process of payment for the services that you receive. In order for this process to flow smoothly, it is essential that you understand what information we must share with each other and with health insurance companies, and what both our responsibilities are.

Upon scheduling and registration we require you to provide your medical insurance card (if you have coverage), photo identification, your address, date of birth, and phone number. If you receive health benefits through a spouse, partner or parent, we require you to provide that person's address, date of birth, and phone number as well. Our billing process works better if you provide social security numbers as well.

Health Insurance Cards: Upon scheduling each appointment, our team will ask to verify your insurance information, and will ask to see your insurance card upon check-in at each appointment. Please bring your card to every appointment, and notify the office at your first appointment after it changes. Intentionally failing to notify us of changes to your insurance coverage may constitute fraud, and we may be obliged to report such behavior to the authorities. We will not engage in any fraudulent practices under any circumstances.

Keeping Appointments: Should you not arrive for a scheduled appointment, unless that appointment has been cancelled at least 1 full business day in advance, you may be charged $25 for each no-show occurrence. Should this occur more than three within a 12 month period, you may be dismissed from the practice. By signing below, you accept this policy.

Health Insurance Plans: It is your responsibility to understand the provisions of your health insurance plan and coverage. As helpful as we pride ourselves on being, our team cannot be expected to know the details of your particular plan, as we see hundreds of different plans every week. We recommend contacting your carrier prior to receiving services in order to verify your coverage levels and responsibilities.

Copayments/Deductibles/Coinsurance: It is our responsibility, as detailed by the terms of our contracts with health insurance to collect any copayment, deductibles, or coinsurance at the time of your appointment. It is your responsibility, as detailed by the terms of your health insurance coverage, to pay any amounts that are your responsibility at the time of your appointment. Please have your payment ready upon check-in. You may be responsible for additional amount at check-out depending on your level of service.
By signing below, you accept these policies.

Previous balances and/or deductibles: It time is our responsibility, as detailed by the terms of our contracts with health insurance companies we participate with, to bill you for any portion of your treatment that your health insurance carrier assigns to your responsibility. It is your responsibility, as detailed by the terms of your health insurance coverage, to pay any such portion. If you do not remit full payment on any such bills within a reasonable period and with reasonable notice, your account will be sent to collections and/or legal action pursued. You may be dismissed as a patient by our practice for failure to meet your financial obligations. Payment arrangements are available.
By signing below, you accept these policies.

Health insurance non-payment: Services that have not been paid by your health insurance carrier within 60 days of claim submission will become your responsibility to pay in full. Should your health insurance carrier later pay us for those services you paid for, you will be reimbursed within 30 days. By signing below, you accept this policy.

Self-pay patients: If you do not have health insurance, have coverage through a carrier with which we do not participate, or are receiving a known non-covered service, it is our policy that you must pay for your service in full before leaving the office. Some cosmetic services require a deposit upon scheduling, which may be taken over the telephone and charged to a credit card, and are not refundable. Should your credit card subsequently be declined or charged back, you will still be responsible for the deposit amounts. By signing below, you accept these policies. A prompt pay discount is available if payment is made in full at time of service.

Return Check Fee: $25.00

FMLA/Disability/Misc Forms: There is a $25 fee charged for any paperwork filled out by your provider.

I have read, fully understand, accept and agree to comply with all the above policies. I consent to the assignment of authorized health insurance benefits by my health insurer to Dallas Medical Physician Group for any services furnished to me or my dependents.

Signature of Patient: _____ Date: _____
If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and indicate relationship to the patient.

Dallas Medical Physician Group

PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FORM

♦ I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it.

♦ I agree that telephone messages regarding my appointments, prescription renewals, lab results, and all other Protected Health Information* ("PHI"), may be left for me on voicemail systems and answering machines at the following telephone numbers, in addition to any other numbers provided to you by me:

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other: _____

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other: _____

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other: _____

[If we need to contact you with lab results, please place a check mark next to the preferred contact number, if any.]

♦ I agree that my Protected Health Information*(PHI), may be shared with the following other people:

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name _____ Relationship_____

♦ I understand that I can change any of the foregoing agreements, at any time, by giving written notice to Dallas Medical Physicians Group.

**as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time ("HIPAA")*

Patient Name (print):_____

Signature: _____ Date: _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): _____ Relationship to Patient: _____