Today's Date: _____
Appt. Time: _____
Arrival Time: _____
Room Time: _____
Room Number: _____
BSWQA or TX HEALTH

Surgical Specialists of North Texas, P.A.

PATIENT HISTORY FORM

Name _____ Preferred name _____ Preferred Phone**: _____**

Birthdate: ____/____/_____ Age: _____ Gender M / F Who is with you today? _____

Family Doctor _____ Referring Physician _____

Have you or a family member seen Dr. Cole in the past? Yes / No If so, who? _____

Why are you here today? _____

MEDICAL HISTORY			
□ Allergies/Hay Fever	□ Chronic steroid use	□ Glaucoma	□ Mental illness
□ Alzheimer's disease	□ COPD or Emphysema	□ Gout	□ Migraines
□ Anemia	□ Crohn's disease	□ Heart disease	□ Pacemaker
□ Anxiety	□ Current pregnancy	□ Heart murmur	□ Parkinson's disease
□ Arthritis	□ Dementia	□ Hepatitis □ A □ B □ C	□ Problems with anesthesia
□ Asthma	□ Depression	□ High cholesterol	□ Stomach ulcer
□ Autoimmune Disease	□ Diabetes □ Use insulin?	□ HIV	□ Stroke
□ Bleeding Disorder	□ Diverticulitis	□ High blood pressure	□ Thyroid disease
□ Blood clots □ DVT □ PE	□ Enlarged prostate	□ Kidney disease	□ Tuberculosis
□ Bronchitis or Pneumonia	□ Epilepsy	□ Kidney stones	□ Ulcerative colitis
□ Cancer (type): _____	□ GERD/Reflux	□ Liver disease	□ Vascular disease
□ Chronic pain			
□ Other (please specify):			

SURGICAL HISTORY			
Procedure	Approx. date	Procedure	Approx. date

CURRENT MEDICATIONS (include over the counter and herbal medications)		**□None**	
Medication name	Dose/How often	Medication name	Dose/How often

MEDICATION ALLERGIES	
Medication name	Type of reaction

SOCIAL HISTORY	
Occupation:	Employer:
Do you smoke or have you smoked in the past? Yes / No How many packs per day? _____ At what age did you start smoking? _____ When did you quit? _____	Highest level degree obtained: (circle one) High School 2 year college 4 year college Post graduate
Alcohol use? Yes / No How much/how often? _____	If a minor, current grade level:

FAMILY HISTORY								
	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother Sister	Children
Anesthesia problems								
Bleeding disorders								
Cancer (what type?)								
Diabetes								
Heart disease								
High cholesterol								
High blood pressure								
Stroke								

REVIEW OF SYSTEMS Do you currently have any of the following symptoms?			
□ Unusual weight loss	□ Shortness of breath with activity	□ Bulging belly button (“an outie”)	□ Easy bleeding
□ Night sweats	□ Persistent cough	□ Bulging in groin(inguinal hernia)	□ Swollen or painful lymph nodes/glands
□ Loss of appetite	□ Wheezing	□ Pain with urination	□ Anxiety or depression
□ Double vision	□ Nausea	□ Blood in urine	□Varicose veins
□ Dry eyes	□ Vomiting	□ Moles that are concerning (painful, change in size, shape, color, bleeding)	□ Leg pain and/or swelling
□ Hearing loss/hearing aids	□ Black tarry stools	□ Lumps under skin	□ Leg heaviness or fatigue
□ Chest pain	□ Blood in stools	□ Breast lumps	□ Leg skin color changes or ulcers
Have you ever had a colonoscopy? Yes / No If so, when?			
□ None of the above apply			

_____ _____ ____/____/_____

Patient’s Name (print) ***Signature of Patient or Personal Representative*** ***Date***

If Personal Representative’s signature appears above, please describe relationship to the patient _____

Office use only

Vitals			
Temp		**Ht**	
BP		**Wt**	
Pulse		**Pain score (0-10)**	

Staff signature: _____

Date of service: _____/_____/_____

Patients Signature: _____ Date: _____

(*Guarantor’s Signature if under 18 years of age*)

Surgical Specialists of North Texas, PA
Timothy Cole, M.D.
(972) 747-0440 / Fax (972) 747-0441

PATIENT REGISTRATION FORM

Date:

Last Name: _____ First Name: _____ Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Social: _____-_____-_____ Email address: _____

Sex: ☐ Male ☐ Female Date of Birth:_____/_____/_____ Race: _____

Ethnicity: ☐ Hispanic ☐ Not Hispanic Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Referred By: _____ Primary Physician: _____

Guarantor Information (*please complete if patient is under 18 years of age*)

Guarantor's Last Name: _____ Guarantor's First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Relationship to the Patient: _____

Insurance Information (*please check one*) ☐ No Insurance/Self Pay ☐ Private Insurance ☐ Medicare ☐ Medicaid

Insurance Name: _____ Insurance Phone Number: _____

Policy Number: _____ Group Number: _____

Policy Holder's Last Name: _____ Policy Holder's First Name: _____

Policy Holder's Date of Birth: _____/_____/_____ Relationship to the Patient: _____

Employer of Policy Holder: _____ Employers Phone Number: _____

CONSENT TO TREAT AND ASSIGNMENT OF BENEFITS

CONSENT TO TREAT: I, the undersigned, hereby consent to and authorize all diagnostic and therapeutic treatment performed at Surgical Specialists of North Texas, PA considered necessary or advisable in the judgment of the physician.
ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private and group insurance, or other health plans to Surgical Specialists of North Texas, PA.
RELEASE OF MEDICAL INFORMATION: I hereby give permission for Surgical Specialists of North Texas; PA 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 RESPONSIBILITY: I accept ultimate financial responsibility for all charges incurred with Surgical Specialists of North Texas, PA whether paid by insurance or not.

Patients Signature: _____ Date: _____

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

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PHARMACY INFORMATION

Please complete the form below with your pharmacy information so that we may send your prescriptions electronically.
If you use more than one pharmacy please list them below.

Patients Name: (Last): _____ (First):_____

Patients Date of Birth: _____/_____/_____

Pharmacy Name: _____

Pharmacy Location: _____

Pharmacy Phone Number: _____

Pharmacy Name: _____

Pharmacy Location: _____

Pharmacy Phone Number: _____

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Patient Consent for Release of Protected Health Information (PHI)

I, _____, give my consent for Surgical Specialists of North Texas, PA to release my protected health information (PHI) to include, but not limited to: physical examination results, laboratory results, x-ray/imaging results, results of other diagnostic studies, medication information/changes, appointments, billing information, etc., to the following individuals:

(Name of Person)	(Relationship to Patient)
_____	_____
_____	_____
_____	_____

I understand that all releases of my medical information will be in compliance with the Surgical Specialists of North Texas, PA Notice of Privacy Practices.
I also consent to Surgical Specialists of North Texas will be leaving telephone messages to remind me of scheduled clinic appointments and to inform me of the need to call the clinic to receive diagnostic test results or other communication at the following telephone number(s):

_____ _____

This consent will expire only with written notification from me.

Patient/Guarantor Signature: _____ Date: _____

The Privacy Rule requires healthcare providers to take reasonable steps to limit the use or disclosure of PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Please note that uses and disclosures for third parties may be permitted without prior consent in an emergency.

Staff Initials: _____

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DISCLOSURE: Drs. Cole has ownership in Craig Ranch Surgery Center, Surgery Center of Plano or Baylor Surgical Hospital at Las Colinas. The investments provide opportunities to retain quality control over your procedures, and to ensure that your costs are reasonable. The ownership means that your physician may benefit from performing your procedure at this facility. Treatment at another facility is possible if you desire.

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Patients Signature: _____ Date: _____
(*Guarantor's Signature if under 18 years of age*)