PATIENT REGISTRATION FORM

Today's date : _____

Clinic Name: ☐ 4325 N JOSEY LN STE 202 CARROLLTON, TX 75010 ☐ 1107 S MacArthur Blvd, Irving, TX 75060
☐ 3427 Trinity Mills, Suite 800 Dallas TX 75287

PATIENT INFORMATION: (Please use full legal name, no nicknames)

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Social Security #: _____

Date of Birth: _____ Age: _____ Sex: _____ Martial Status: _____

Employer Name and Address: _____

_____ Work Phone #: _____

E-mail address: _____Cell Phone #:_____

Emergency Contact:

Full Name: _____Emergency Phone #:_____Relationship:_____

Responsible Party: (if patient is minor)

Relationship to patient: Self _____ Spouse _____ Parent _____ other _____

Last Name: _____ First Name: _____ Middle initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Social Security #: _____

Date of Birth: _____ Age: _____ Sex: _____ Martial Status: _____

Employer Name and Address: _____

_____ Work Phone #: _____

Preferred Pharmacy (list address): _____

PATIENT'S HISTORY

NAME: _____ BIRTHDAY (MM/DD/YY): _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

ADDRESS: _____

Married _____ Single _____ Divorced _____ Widowed _____

Level of education: _____ # of people in household: _____ # of children: _____ Occupation: _____

LIST EVERY SURGERY AND HOSPITAL STAY (INCLUDING DATE AND REASON)

_____
_____
_____
_____

HAVE YOU HAD ANY OF THE FOLLOWING? (CIRCLE EACH CONDITION)

HEART DISEASE, DIABETES, HIGH BLOOD PRESSURE, HIGH CHOLESTEROL, ALCOHOLISM, MENTAL ILLNESS, ADDICTION, ARTHRITIS, THYROID PROBLEMS, CANCER, LIVER DISEASE, BACK TROUBLE, MIGRAINES,EMPHYSEMA

OTHER CHRONIC CONDITION (SPECIFY): _____

LIST EVERY CURRENT MEDICINE (INCLUDING STRENGTH AND # OF DOSES DAILY)

_____
_____
_____
_____

LIST ALL DRUG ALLERGIES (INCLUDING NATURE OF REACTION)

_____

LIST APPROXIMATE DATE OF THE LAST: PHYSICAL OR PAP SMEAR EXAM _____MAMOGRAM _____

BONE DENSITY TEST_____ EKG _____ STRESS TEST _____

COLONOSCOPY _____ X-RAYS _____

FOR ALL THE ABOVE, PLEASE EXPLAIN IF RESULTS WERE ABNORMAL: _____

APPROXIMATE DATE OF LAST VACCINE: TETNUS _____ FLU _____ PNEUMOVAX _____ HEP B _____

DO YOU SMOKE? NO YES # of packs a day _____ Age started _____

DO YOU DRINK ALCOHOL? NO YES How many alcoholic beverages a week? _____

DO YOU USE RECREATIONAL DRUGS? NO YES

DO YOU THINK YOU ARE AT RISK FOR AIDS FROM UNSAFE SEX OR IV OR DRUG USE? NO YES
If yes, Do u want an HIV test? NO YES

PATIENT SIGNATURE: _____ DATE: _____

Care 1st Family Practice
Patient Policies/Confidentiality Statement

Please sign and date to confirm that you received a copy of our patient policies and Confidentiality Statement and please give back to the receptionist so that we may keep a copy in your chart.

Thank You,

Management

_____ _____

Signature **Date**

Financial Responsibility Agreement

Patient Name: _____D.O.B:_____

I understand that I will be held financially responsible for any and all charges not paid by my insurance for my visits. This includes any medical services or visit, preventative exam or physical, lab testing, X-ray, EKG and any other screening service or diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the physician or clinic to know if my insurance will pay for my medical service or visit, preventative exam or physical, lab testing, X-ray, EKG, or any other screening service or diagnostic testing ordered by the physician or the physician's staff.

I understand and agreed it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amount, usual and customary limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to know if my PCP choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be fully financially responsible and make full payment.

Signature:_____ Date:_____

Responsible Party Name:_____

Relationship:_____

GETTING TO KNOW YOUR INSURANCE BENEFITS

Many patients have found that knowing their insurance benefits takes much of the financial surprise out of healthcare. While good health is priceless, most of us have budgetary considerations, which, with careful planning can reduce some of the financial burden we sometimes feel. Each insurance plan offers something different even within one insurance carrier. Even with good health insurance, not every service will be covered in full and the patient is left with the responsibility to pay the amount not covered.

Some insurance policies require that a deductible be met before coverage begins. For example, if you have a $2500 deductible, the patient must pay that amount before any expenses are paid by the insurance company. The deductible must be met before the copay is used. Your insurance company can tell you how much of your deductible has been met to date. Some insurance plans have in place multiple deductibles such as one for procedures and lab tests and a different one for office visits. Again, your insurance company can provide this information.

Other insurance plans have a coinsurance requirement, which means the patient and the insurance company each pay a specific percentage of the day's visit. Your insurance company can provide information about the allowable amounts.

Our reception team has tables from some insurance companies listing the allowable amounts, meaning the contracted amounts we are to charge for a specific service. It is the clinic policy to collect the fees for service at the time the service has been performed. To make this as painless as possible, we are able to process several different forms of payment. We accept Visa, Mastercard and Discover credit cards. We accept personal checks as well as cash.

Thank you for choosing us for your healthcare needs.