SURGERY ASSOCIATES OF NORTH TEXAS

PATIENT NAME: _____ DOB: _____

Thank you for choosing us as your healthcare provider.

WHO IS YOUR FAMILY DOCTOR? _____

HOW DID YOU HEAR ABOUT US? (Please circle one of the below):

CARE NOW ER Medical City Denton OTHER ER _____ (Hospital)

WEBSITE GOOGLE YELLOW PAGES

OTHER SEARCH ENGINE: _____ (Name)

INSURANCE COMPANY WORKERS' COMP

FRIEND/FAMILY _____ (Name)

SPECIALIST _____ (Name) FAMILY DOCTOR _____ (Name)

OTHER _____

PLEASE CIRCLE THE DOCTOR YOU ARE SEEING TODAY:

Robert Connaughton, MD Carlos P. Cruz, MD Stephen Lester, MD

PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last)_____(First)_____(MI) _____

Preferred Full Name (if different from above): _____ Patient Social Security Number:_____-_____-_____

Address: _____

City, State, Zip: _____Employer:_____

Home Phone Number (landline):_____Cell:_____Work: _____

E-Mail Address:_____Date of Birth: _____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose
☐ Additional Gender category not listed _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White
☐ Hispanic ☐ Chose not to disclose ☐ Other not listed _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Indian: Hindi, Tamil, Gujarati etc
☐ Swahili ☐ Russian ☐ Arabic ☐ Vietnamese ☐ Haitian Creole ☐ Bosnian/Croatian/Serbian/Serbo-Croatian
☐ Albanian ☐ Burmese ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Portuguese ☐ Cambodian ☐ Other not listed_____

Marital Status: _____ Preferred Pharmacy: _____

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐
Responsible party name: (Last)_____(First)_____(MI) _____

Date of birth: MM_____/DD_____/YYYY_____ Sex: ☐ Female ☐ Male

Responsible Party Social Security Number:_____-_____-_____Phone number: _____

Address:_____

City, State:_____ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)_____ (First) _____

Phone number:_____ Do you have a living will? ☐ Yes ☐ No

Emergency contact relationship to patient:_____ ☐ Guardian

Address_____

City, State:_____ZIP: _____

Home phone:_____Work hone:_____Ext. _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:_____Date: _____

Printed name of patient or personal representative:_____Relationship to patient: _____

Surgery Associates of North Texas

Patient name: _____

Date of birth: _____

Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, Lone Star Medical Group may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge Lone Star Medical Group may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to Lone Star Medical Group any insurance or other third-party benefits available for health care services provided to me. I understand Lone Star Medical Group has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Lone Star Medical Group, I agree to forward all health insurance or third party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Lone Star Medical Group by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for Lone Star Medical Group, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Lone Star Medical Group or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Lone Star Medical Group or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: _____ Date: _____

If you are not the patient, please identify your relationship to the patient.

Circle or mark relationship(s) from list below:

Spouse Guarantor

Parent Healthcare Power of Attorney

Legal Guardian Other (please specify) _____

SURGERY ASSOCIATES OF NORTH TEXAS
MEDICAL HISTORY

NAME: _____ Date: _____

DOB: _____ Height: _____ Weight: _____

Have you ever been diagnosed with: ___diabetes ___cirrhosis ___hepatitis ___DVT

___COPD ___congestive heart failure ___heart disease ___asthma ___blood transfusions

List any other medical conditions:

Please list all surgeries you have had:

Are you allergic to latex or tape?_____
Have you ever had any problems with anesthesia? YES NO
If yes, please explain:

MEDICATION ALLERGIES: _____

MEDICATIONS: Please include supplements. (Or provide a copy of your medication list)

FAMILY HISTORY (Relatives with high blood pressure, heart disease, diabetes, aortic aneurysm, or cancer, etc):

Do you drink alcohol? ___NO ___Yes ___Daily ___Weekly ___Occasionally

Do you use tobacco? ___Yes ___Smoke ___Chew How much per day?_____ For how long? _____

___Never smoked ___Used To How long have you been quit?_____

Do you use illicit drugs? ___NO ___Yes Illicit IV drugs? ___NO ___Yes

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Are you pregnant? ___NO ___Yes ___Unsure Date of last menstrual period _____
# of pregnancies: _____ # of live births: _____ # of miscarriages: _____

SURGERY ASSOCIATES OF NORTH TEXAS

NAME: _____ DATE: _____

What is the reason for your visit today? _____

Please circle any other problems you are having today:

GENERAL: None Fever Chills Weakness Tired Unexplained weight loss Unexplained weight gain

HEAD/NECK: None Headaches Difficulty swallowing Sore throat Lumps or swollen glands

EYES/EARS: None Vision changes Blurred vision Hearing loss Ringing in ears Nosebleed

HEART: None Chest pain Palpitations Skipping beat, pounding, or racing heart

Shortness of breath with activity Fainting or near-fainting

LUNGS: None Shortness of breath Nonproductive cough Productive cough Blood in sputum

GASTROINTESTINAL: None Heartburn Reflux Change in appetite Nausea Vomiting

Change in bowel habits Diarrhea Constipation Rectal bleeding Blood in stool Black tarry stool

MUSCULOSKELETAL: None Back pain Joint pain Muscle aches Muscle cramps Difficulty walking

SKIN: None Rashes Lumps Color change Easy bruising Changes hair/nails

NEUROLOGIC: None Confusion Dizziness Fainting Memory changes Numbness

PSYCHIATRIC: None Anxiety Depression Hallucinations

HEMATOLOGIC: None Bleeding Easy bruising

Have you had your flu shot? _____ If so, when? _____

Have you had your pneumonia shot _____ If so, when? _____

_____ _____

Patient Signature Date

FIRST POINT OF CONTACT SCREENING

Patient Name_____ **Date**_____
Please print full legal name

We are committed to providing the safest environment for our patients and together we can prevent the spread of germs.

Please complete the questionnaire below. If you answer yes to any of the questions, please be considerate of others and act appropriately such as covering your cough, washing your hands, and covering any open wounds.

For the protection of our patients, we gladly supply and encourage the use of tissue, masks, hand sanitizer, and Band-Aids.

1. Do you have any of the following symptoms? YES NO

   If yes, please circle the symptoms you have now, or have had, over the past seven days?

   - **Fever**
   - **Night sweats**
   - **Sneezing or runny nose**
   - **Cough**
   - severe headache
   - stiff neck
   - muscle or joint pain (circle one or both)
   - new rashes or open sores on your skin or in your mouth
   - redness, swelling, or discharge of your eyes (pink eye)
   - unexplained bleeding
   - vomiting or diarrhea

2. In the past three weeks, have you traveled outside the U.S.? YES NO

If yes, please list where: _____

3. In the past three weeks have you had close contact with someone who has traveled outside the U.S.? YES NO

   If yes, please list where: _____

Thank you for your help and support in caring for our patients and community.

TO BE FILLED OUT BY OFFICE STAFF

Reviewed by:_____

Action taken:

- ☐ No action taken
- ☐ Isolate
- ☐ Cough/ hand washing etiquette provided
- ☐ Mask provided
- ☐ PM/ Lead clinical notified

Thank you for trusting us with your healthcare!

Fall Risk Assessment age 65 and older

Please Note: This screening is required by federal mandate to be completed annually.

Patient Name & Date of Birth _____
Date: _____

Increased Fall Risk Factors (check all that apply):

- ___ Diagnoses (Do you have 3 or more existing Medical Conditions?)
- ___ Do you have a prior history of falls within 3 months?
- ___ Incontinence (Do you have an uncontrolled bladder?)
- ___ Visual Impairment (Do you have trouble seeing?)
- ___ Impaired functional mobility (Do you use a cane or walker?)
- ___ Environmental Hazard (Do you have stairs or loose rugs at home?)
- ___ Polypharmacy (Do you take more than 3 medications?)
- ___ Pain affecting level of function (Does pain keep you from performing your daily activities?)
- ___ None of the above

History of falls in the past year YES NO

If yes, please answer below:
How many falls in the last year? _____

Did you have any injuries as the result of a fall?

Please explain: _____

_____

SURGERY ASSOCIATES OF NORTH TEXAS

Accessing the Patient Portal

WE HOPE YOU LIKE OUR PORTAL

- You can send a non-urgent message or question to the nurse.
- Request refills.
- View your medical records.
- Make an appointment

For your convenience and easy access, you can visit our website at www.surgeryassociates-nt.com, and you will see the link to the portal in the upper right corner of our website.

Getting Started:

- Be sure you are accessing the clinic patient portal and not the hospital.
- The first time must be done from a computer. Internet Explorer, Safari, and Google Chrome are the approved web browsers.
- Your user name is your email address. You will receive an email with a temporary password. Passwords must be typed and not copied / pasted.
- You must enter the last 4 of your social security number. Use 9999 if you did not provide us with your SSN.
- DOB format must be MM/DD/YYYY and phone number must be 2223334444 (no dashes or special characters)

Trouble accessing the portal or locked out? Please call us at (940) 387-7588! We can verify if you have access, correct your email, and/or reset your password. Password resets take 3 minutes.