

Patient Registration Form (eCW)

(Please Print)

PATIENT INFORMATION

Dr. Miss Mr. Mrs. Ms. Sir

Patient's Name (Last) (First) (MI) Previous Name

Address Line 1

City, State ZIP

Home Phone Cell No. Work Phone Ext.

Primary Care Provider (PCP) Referring Provider

Rendering Provider Name (this practice) E-Mail Address:

Date of Birth MM/DD/YYYY Sex F - Female M - Male Transgender

Race American Indian/Alaska Native Asian Native Hawaiian/Pacific Islander Black/African American White Hispanic Other Declined

Language English Spanish Indian Japanese Chinese Korean French German Russian Other

Ethnicity Hispanic or Latino Not Hispanic or Latino Declined

Marital Status Married Single Divorced Widowed Legally Separated Partner

Social Security Number Employer Name

Employment Status 1 - Full-Time 2 - Part-Time 3 - Not Employed 4 - Self-Employed 5 - Retired 6 - Active Military

Student Status F - Full-Time Student P - Part-Time Student N - Not a Student

Emergency Contact Last Name First Name

Phone Number Do you have a living will? Yes No

Emergency Contact Relationship to Patient Guardian

Address Line 1

City, State ZIP

Home Phone Work Phone Ext.

Referring Provider Name

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party Another Patient Guarantor Self Check here if information is same as patient

Responsible Party Name (Last) (First) (MI)

Guarantor Account Number Date of Birth MM/DD/YYYY

Social Security Number Telephone

E-Mail Address Sex F - Female M - Male

Address Line 1

City, State ZIP

Employer Employer Phone Number

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number

Name of Insured Patient Relationship to Insured

Subscriber ID (Policy Number) Group ID Copay Amount

Effective Date Termination Date Date of Birth MM/DD/YYYY

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number

Name of Insured Patient Relationship to Insured

Subscriber ID (Policy Number) Group ID Copay Amount

Effective Date Termination Date Date of Birth MM/DD/YYYY

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature Date

## 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**

\_\_\_\_\_  
**Printed Name of Witness**

\_\_\_\_\_  
**Employee Job Title**

\_\_\_\_\_  
**Signature of Witness**

\_\_\_\_\_  
**Date**

# Surgical Specialist of Clear Lake

## Patient Information

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **SEX:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

REFERRING DOCTOR: \_\_\_\_\_

PLEASE CHECK **ALL** PREVIOUS AND CURRENT ILLNESSES OR CONDITIONS BELOW:

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Jaundice             | <input type="checkbox"/> Arthritis           |
| <input type="checkbox"/> Heart Attack            | <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Deep Venous Thrombus | <input type="checkbox"/> Back injury         |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Other Lung Problems | <input type="checkbox"/> HIV                  | <input type="checkbox"/> Depression          |
| <input type="checkbox"/> Heart Failure           | <input type="checkbox"/> Ulcers              | <input type="checkbox"/> Sickle Cell          | <input type="checkbox"/> Psychiatric Illness |
| <input type="checkbox"/> Other Heart Problems    | <input type="checkbox"/> Diverticulitis      | <input type="checkbox"/> Bleeding Disorders   | <input type="checkbox"/> Glaucoma            |
| <input type="checkbox"/> High Cholesterol        | <input type="checkbox"/> Gallstones          | <input type="checkbox"/> Blood Transfusions   | <input type="checkbox"/> Eye Problems        |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Hernias             | <input type="checkbox"/> Anemia               | <input type="checkbox"/> Cancer              |
| <input type="checkbox"/> Thyroid Problems        | <input type="checkbox"/> Cirrhosis           | <input type="checkbox"/> Kidney Stones        | <input type="checkbox"/> Sleep Apnea         |
| <input type="checkbox"/> Pulmonary Embolus       | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Urinary Problems     | <input type="checkbox"/> Other               |

If you marked "Other", please explain:

\_\_\_\_\_

**Past Surgeries:**  None

\_\_\_\_\_

**Current Medications:**  None

\_\_\_\_\_

**Medication Allergies:**  None

\_\_\_\_\_

**Family History:**  None  Heart Disease  Diabetes  Cancer

Have you **ever Smoked?** No  Yes  If yes, \_\_\_\_\_ packs a day for \_\_\_\_\_ years. Quit? \_\_\_\_\_

Do you drink **alcohol?**  No  Yes If yes, \_\_\_\_\_ drinks a week of  Wine  Beer  Liquor

Check Symptoms you currently have or have had in the past year:

- |  |   |   |   |
|--|---|---|---|
| <b><u>CONSTITUTIONAL</u></b>                   | <input type="checkbox"/> Palpitations         | <input type="checkbox"/> Constipation         | <input type="checkbox"/> Stroke/TIA         |
| <input type="checkbox"/> Fever                 | <input type="checkbox"/> Chest Pain           | <input type="checkbox"/> Bloody Stools        | <input type="checkbox"/> Weakness           |
| <input type="checkbox"/> Weight Loss           | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Stool Caliber Change | <b><u>HEMME/IMMUNO</u></b>                  |
| <input type="checkbox"/> Heat/Cold Intolerance | <b><u>REPIRATORY</u></b>                      | <input type="checkbox"/> Stool Color Change   | <input type="checkbox"/> Bleeding Disorders |
| <b><u>EYES</u></b>                             | <input type="checkbox"/> Shortness of Breath  | <b><u>SKIN &amp; BREAST</u></b>               | <input type="checkbox"/> Blood Transfusions |
| <input type="checkbox"/> Glasses/Contact       | <input type="checkbox"/> Cough                | <input type="checkbox"/> Skin Lesions         | <input type="checkbox"/> Large Lymph Glands |
| <input type="checkbox"/> Blurry Vision         | <input type="checkbox"/> Wheezing             | <input type="checkbox"/> Breast Mass          | <b><u>MUSCULOSKELETAL</u></b>               |
| <b><u>EARS &amp; THROAT</u></b>                | <b><u>GASTROINTESTINAL</u></b>                | <b><u>URINARY</u></b>                         | <input type="checkbox"/> Arthritis          |
| <input type="checkbox"/> Difficulty Hearing    | <input type="checkbox"/> Nausea               | <input type="checkbox"/> Incontinence         | <input type="checkbox"/> Bone Pain          |
| <input type="checkbox"/> Loose Teeth           | <input type="checkbox"/> Vomiting             | <input type="checkbox"/> Frequency            |   |
| <input type="checkbox"/> Dentures              | <input type="checkbox"/> Heartburn            | <input type="checkbox"/> Urgency              |   |
| <b><u>CARDIAC</u></b>                          | <input type="checkbox"/> Poor Appetite        | <b><u>NEUROLOGIC</u></b>                      |   |

Other/Explanation: \_\_\_\_\_

Date of last colonoscopy: \_\_\_\_\_

**For Women ONLY:** Last Mamogram: \_\_\_\_\_ Last Pap Smear: \_\_\_\_\_

Number of Pregnancies: \_\_\_\_\_ Age you started menstruating: \_\_\_\_\_ Menopause: \_\_\_\_\_

Have you ever taken Birth Control Pills: \_\_\_\_\_ Have you ever taken Hormone Replacement Therapy: \_\_\_\_\_

**Surgical Specialists of Clear Lake, PLLC**

**PATIENT NAME** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_

**PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS**

1. \_\_\_\_\_ (Patient or Guardian Initials)

**Financial Agreement.**

- I acknowledge, that as a courtesy, **SURGICAL SPECIALISTS OF CLEAR LAKE, PLLC** 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 that there is a fee for returned checks.

2. \_\_\_\_\_ (Patient or Guardian Initials)

**Third Party Collection.** I acknowledge that **SURGICAL SPECIALISTS OF CLEAR LAKE, PLLC** may utilize the services of a third party business associate or affiliated entity as an extended business office (“EBO Servicer”) for medical account billing and servicing.

3. \_\_\_\_\_ (Patient or Guardian Initials)

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

4. \_\_\_\_\_ (Patient or Guardian Initials)

**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 **SURGICAL SPECIALISTS OF CLEAR LAKE, PLLC** by the Medicare or Medicaid program.

5. \_\_\_\_\_ (Patient or Guardian Initials)

**Consent to Telephone Calls for Financial Communications.** I agree that, in order for **SURGICAL SPECIALISTS OF CLEAR LAKE, PLLC**, 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 **SURGICAL SPECIALISTS OF CLEAR LAKE, PLLC** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **SURGICAL SPECIALISTS OF CLEAR LAKE, PLLC** 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 pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. \_\_\_\_\_ (Patient or Guardian Initials)

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

Patient/Patient Representative Signature:

X \_\_\_\_\_ Date \_\_\_\_\_

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

Spouse

Guarantor

**Surgical Specialists of Clear Lake, PLLC**

**PATIENT NAME** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_

Parent

Healthcare Power of Attorney

Legal Guardian

Other (please specify) \_\_\_\_\_