Office: 817.912.9530
Fax: 817-912-9540

PATIENT REGISTRATION
(If this is a Workman's Compensation claim, please notify us at check in.)

Office Use Only- Chart #________________________

This form must be completed before seeing the Doctor to ensure accurate records for your medical file and secure payment from your insurance company. Payment arrangements must be made at time of service.

Patient's Last Name ________________________ First Name ________________________ Middle Initial ______

Social Security # ________________________ Race ________________ Marital S ❒ M ❒ D ❒ W ❒

Gender M ❒ F ❒ Transgender M ❒ F ❒ Date of Birth ________________________ Age____________

Address ________________________ City ________________ State __________ ZIP __________

Home Phone ________________________ Work ________________ Cell ________________________

Email Address ____

How did you hear about us? ______________ Which Provider are you here to see? ________________

Emergency Contact Information

Name ________________________ Relationship ______________ Phone ________________

Policy Holder Information (if different from the patient)

Policy Holder / Subscriber Name ________________________________ Date of Birth ______________

Relationship to Patient ________________ Social Security # ________________ Gender M ❒ F ❒

Address ________________________ City ________________ State ________ ZIP __________

Please indicate whether the information above is for the ❒ primary or ❒ secondary insurance. The health insurance information provided above is complete. I have no other health care coverage. ________Initial

Primary Care Physician Name ________________________________ Phone ________________

Referred by ❒ Physician ❒ Friend ❒ Website Website Address ________________________

Referring Physician's Name ________________________ Phone ________________________

Employment Information

Employer ________________________________ Occupation ________________________

Address ________________________________ Phone ________________________

Pharmacy Information

Name ________________________________ Phone ________________________

I give permission to Surgical Group of North Texas, LLP and any of the staff to release any information regarding my medical records or billing records to the following individual / individuals:

____

Signature ________________________________ Date ________________________

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MEDICAL HISTORY

Last Name ______________________ First Name ______________________ Middle Initial ________

Gender M ❒ F ❒ Transgender M ❒ F ❒ Age: _____ Date of Birth: ______________ Marital S ❒ M ❒ D ❒ W ❒

Please state the reason for coming to the doctor today. ____________________________________

____

HAVE YOU HAD SURGERY BEFORE TODAY? (Please check all that apply and **include year**.)

❒ Appendectomy ____________ ❒ Hernia: ❒ Left ❒ Right ❒ Umbilical ____________

❒ Breast Biopsy ____________ ❒ Hysterectomy ______________________

❒ Breast Cancer Surgery ____________ ❒ Open Abdominal Surgery ______________________

❒ Coronary Artery Bypass ____________ ❒ Removal of Ovary: ❒ Left ❒ Right ____________

❒ Gallbladder ____________ ❒ Other ______________________

DO YOU HAVE ANY MEDICAL PROBLEMS? (Please **check or list** all that apply.)

❒ Diabetes ❒ Type I ❒ Type II ❒ Asthma ❒ Lung Cancer ❒ High Blood Pressure

❒ Emphysema ❒ Stroke ❒ Kidney Problems ❒ Dialysis

❒ Reflux ❒ Liver Problems ❒ Stomach Ulcer ❒ Heart Disease

❒ Blood Clotting Problems ❒ Irregular Heart ❒ Congestive Heart Failure ❒ Thyroid Disease

❒ High Cholesterol ❒ Other ______________________

** WHEN WAS THE LAST TIME YOU HAD THE FOLLOWING? **

Year of Last Pap Smear: ____________ Year of Last Mammogram: ____________

Year of Last Colonoscopy: ____________ Year of Last Flu Vaccine: ____________

Year of Last Pneumonia Vaccine: ____________ Any recent travel to Caribbean, Central America or South America?

❒ Yes ❒ No

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MEDICAL HISTORY

Last Name ______________________ First Name ______________________ Middle Initial ________

Gender M ❒ F ❒ Transgender M ❒ F ❒ Age: _____ Date of Birth: ______________ Marital S ❒ M ❒ D ❒ W ❒

DO YOU TAKE ANY MEDICATIONS? (Please **check or list** all that apply.) ❒ Yes ❒ No
If yes, please list below which medications, dosage and frequency taken.

❒ Aspirin (81 mg or 325 mg) ❒ Coumadin ❒ Effient ❒ Eliquis

❒ Plavix ❒ Pradaxa ❒ Other Blood Thinners

MEDICATION LIST

1. ______________ 4. ______________ 7. ______________
2. ______________ 5. ______________ 8. ______________
3. ______________ 6. ______________ 9. ______________

10. ______________

**** DO YOU HAVE ANY ALLERGIES OR ILL EFFECTS FROM MEDICATION? **** ❒ Yes ❒ No (Please list below)

____

____

____

SOCIAL HISTORY

Tobacco Use ❒ Former ❒ Never ❒ Yes _______ packs/day _____ years ❒ Other Drug Use ______________

Alcohol Use ❒ Former ❒ Never ❒ Yes _______ drinks/day ______________

Age of First Period ________ Age of First Childbirth ______________ ❒ Premenopausal ❒ Postmenopausal

ARE THERE MEDICAL PROBLEMS IN YOUR FAMILY (within the first degree - example: parents, siblings children)? (Please check all that apply and specify relationship.)

❒ Arthritis ______________ ❒ High Blood Pressure ______________

❒ Breast Cancer ______________ ❒ Lung Disease ______________

❒ Colon Cancer ______________ ❒ Ovarian Cancer ______________

❒ Diabetes ______________ ❒ Prostate Cancer ______________

❒ Heart Disease ______________ ❒ Stroke ______________

❒ Other Cancers ______________ ❒ Other Diseases ______________

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BaylorScott&White
SURGICAL GROUP OF NORTH TEXAS

REVIEW OF SYSTEMS

Last Name ______________________________ First Name ________________________ Middle Initial _________

Gender M ❒ F ❒ Transgender M ❒ F ❒ Age: ____ Date of Birth: ________________ Marital S ❒ M ❒ D ❒ W ❒

HAVE YOU EXPERIENCED ANY OF THESE SYMPTOMS RECENTLY? (Please check all that apply.)

CONSTITUTIONAL

❒ Chills ❒ Fatigue ❒ Lethargy ❒ Persistent Fever
❒ Weakness ❒ Weight Loss

EARS, NOSE, MOUTH, THROAT

❒ Ear Drainage ❒ Hoarseness ❒ Loss of Hearing ❒ Mouth Pain
❒ Nasal Congestion ❒ Nose Bleeds ❒ Sinus Problems ❒ Sore Throat
❒ Throat Swelling ❒ Tongue Pain / Swelling ❒ Toothache ❒ Voice Changes

ENDOCRINE

❒ Cold Tolerance ❒ Heat Tolerance ❒ Increased Thirst ❒ Increased Urine
❒ Thyroid Dysfunction ❒ Weight Gain ❒ Weight Loss

GASTROINTESTINAL

❒ Abdominal Pain ❒ Anorexia ❒ Blood in Stool ❒ Constipation
❒ Diarrhea ❒ Painful Swallowing ❒ Rectal Pain ❒ Reflux
❒ Vomiting Blood

GENITOURINARY

❒ Blood in Urine ❒ Frequent Urination ❒ Painful Urination ❒ Testicular Pain
❒ Testicular Swelling ❒ Urgent Urination ❒ Urinating at Night

HEART

❒ Chest Pain or Discomfort ❒ Inability to Lie Flat ❒ Leg Swelling ❒ Palpitations
❒ Shortness of Breath on Exertion

LUNGS

❒ Coughing up Blood ❒ Non Productive Cough ❒ Pain with Breathing ❒ Pneumonia
❒ Productive Cough ❒ Shortness of Breath ❒ Wheezing

MUSCULOSKELETAL

❒ Arthritis ❒ Back Pain ❒ Extremity Swelling ❒ Joint Pain
❒ Joint Swelling ❒ Muscle Pain ❒ Neck Pain

NEUROLOGIC

❒ Bladder Problems ❒ Bowel Problems ❒ Confusion ❒ Fainting
❒ Headaches ❒ Lightheadedness ❒ Numbness ❒ Problems Walking
❒ Seizure ❒ Vision Changes ❒ Weakness

PSYCHOLOGIC

❒ Agitation ❒ Anxiety ❒ Confusion ❒ Depression
❒ Hallucinations ❒ Insomnia ❒ Stress

SKIN

❒ Abrasion ❒ Bruising ❒ Itching ❒ Lacerations
❒ Rashes