PATIENT REGISTRATION FORM

(**PLEASE PRINT**)

Today's Date: _____ Doctor : ☐ Dr. William M. Carpenter
☐ Dr. David E. Morales Referred By:_____

Patient Information

First Name: _____ **Middle**: _____ **Last**:_____

Preferred Name: _____

Address: _____ City/State/Zip:_____

Home Phone: _____ Cell: _____ E-mail: _____

Social Security Number:_____ Birthdate:_____ Age:_____

Employer Name:_____Work Phone:_____

Employer Address: _____ City/State/Zip:_____

Spouse:_____ Occupation:_____ Cell Phone:_____

Employer:_____ Employer Phone:_____

Primary Care Physician:_____ Main Number:_____

Address:_____ City/State/Zip _____

Nature of Visit:_____

Who to call for an emergency:

Name:_____ Relationship:_____

Home Phone:_____ Cell Phone:_____

***** Please complete section below only if insurance applies*****

(Please allow receptionist to photocopy your insurance ID cards and Driver's License)

Primary Insurance Information

Plan Name:_____ Group#:_____ ID#:_____

Policy Holder:_____ Social Security#:_____ DOB:_____

Secondary Insurance Information

Plan Name:_____ Group#:_____ ID#:_____

Policy Holder:_____ Social Security#:_____ DOB:_____

TREATMENT AUTHORIZATION: The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this staff of any changes in my medical condition. I authorize the above physician and his staff to perform the necessary treatment.

Responsible Party Signature:_____ Date:_____

MEDICAL HISTORY

(PLEASE PRINT)

Note: This is a confidential report of your medical history. Information contained here will be released only if you have authorized us to do so.

Name:_____ **Date**:_____

Past Medical History:

Check any conditions that you have had:

- ○ Abnormal EKG
- ○ Anemia
- ○ Arthritis
- ○ Asthma
- ○ Bleeding Disorder
- ○ Breast Lump
- ○ Cancer
  Type:_____
- ○ Heart Disease
- ○ Depression
- ○ Diabetes Type I
- ○ Diabetes Type II
- ○ Epilepsy
- ○ Heart Attack
- ○ Hepatitis
- ○ High Cholesterol
- ○ HIV
- ○ Hypertension
- ○Intestinal Disease
- ○ Lung Problems
- ○ Stroke
- ○ Thyroid
  Type:_____

Other major health problems:_____

_____

_____

Date of last mammogram: _____
(if applies)

Past Surgical History:

Have you ever had surgery? ○ Yes ○ No

If yes, please list:

Type: _____ Year:_____

Type: _____ Year:_____

Type: _____ Year:_____

Recent Hospitalizations: _____

_____

Medications:

List all medicines and supplements you take:

Medicine or Supplements	How much?	How often?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies:

Are you allergic to any medications? ○ Yes ○ No

Please list: _____

_____

_____

Are you allergic to Latex? ○ Yes ○ No

Are you pregnant? ○ Yes ○ No

Have you had a tubal ligation? ○ Yes ○ No

Do you smoke? ○ Yes ○ No If you ever smoked, when did you stop? _____

Have you or anyone in your family ever had problems with general anesthetic? If so, What occurred? _____

_____

Pharmacy Name: _____ **Phone**: _____

Pharmacy Address: _____

FINANCIAL POLICY

Doctor: ☐ William M. Carpenter

☐ David E. Morales

We sincerely thank you for choosing our office for your healthcare needs. Please understand that payment of your bill is considered part of your treatment. Filing your insurance is a service provided to you free of charge, but in no way relieves you of the responsibility of your bill, (i.e. deductible, usual and customary rates and services not covered by your plan). The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment.

INSURANCE COVERAGE: Insurance is designed to reduce your costs, but usually will not eliminate them entirely. You are fully responsible for all fees charged by this office regardless of your insurance coverage. We will make every effort to fully inform you of all fees due and your insurance payment status. We try our best to verify your insurance coverage before you receive treatment; however, this is not always the case. This office does not accept total responsibility for verifying your insurance or for collecting your insurance claim. Ultimately the responsibility is that of the policyholder.

Thank you very much. We look forward to serving you.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AND ALL CHARGES INCURRED BY ME IN THIS OFFICE EXCEPT FOR CHARGES REQUIRED TO BE WRITTEN OFF BY CONTRACTUAL AGREEMENT. I HAVE READ, UNDERSTAND, AND AGREE TO THE PROVISIONS OF THIS FINANCIAL POLICY.

_____ _____

Signature Date

PAYMENT OF BENEFITS: I hereby authorize payment of benefits to the above indicated physician for services performed. I understand that I am financially responsible for charges not covered by this assignment.

_____ _____

Signature Date

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PATIENT AUTHORIZATION: I authorize the release of any medical information necessary to process this claim. This information will be used for the purpose of evaluating and administering claims for benefits. I agree that a photographic copy of this authorization is as valid as the original.

_____ _____

Signature Date

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Personal Representative Date

I will allow the following individual(s) to have access to my medical file: _____

CONSENT FOR TAKING and USE OF PHOTOGRAPHS and DIGITAL IMAGES

Patient's Name _____

Requested by**:** (Check your doctor's name listed below.)

_____ **William M. Carpenter, M.D.**
_____ **David E. Morales, M.D.**

I certify that I am the Patient or Legal Guardian of the above named patient and herby consent that photographs or digital images may be taken of the above named patient or parts of such patient's body under the following conditions and used for the following reasons:

1. The photographs or digital images may be taken at the consent of such patient's physician and shall be taken by the physician or photographer approved by the physician.
2. I authorize the physician to use my photographs or digital images for the following: insurance purposes, educational and/or scientific purposes.

(PLEASE CIRCLE "YES" OR "NO" FOLLOWING THE STATEMENT BELOW)

My **NON-IDENTIFYING** photos may be used for patient/physician education online and in print materials.

YES **NO**

I understand that all photographs and digital images viewed whether of the patient or other individuals are demonstrative in purpose and are only a representation of the possible result that could be achieved through the proposed surgery.
I understand that the patient will not ever be identified by name, but that such photographs or digital images may reveal my identity. I accept this loss of anonymity.

This authorization is granted in furtherance of medical education, knowledge, research or the general public welfare and as a voluntary contribution. I/we herby waive all right I/we might have to such photographs and digital images and do hereby release discharge and save harmless Baylor University Medical Center and its employees and agents from all claims and liabilities whatsoever in law and in equity arising from such used.

Patient/Guardian Signature: _____ **Date**: _____
Print Name of Patient _____
Witness Signature: _____ **Date:** _____