

ROCKWALL SURGICAL SPECIALISTS

DAVID RITTER, MD ▪ ASHLEY EGAN, MD ▪ JON HARRIS, MD ▪ JOSHUA MARK, MD

PH: (972) 412-7700 FX: (972) 412-7710/(469) 402-3055

PATIENT REGISTRATION FORM

Patient's name (Last, First, Middle Initial)

Sex (M or F)

Date of Birth

Address

City

State

Zip

Home Phone

Cell Phone

Email

May we leave a detailed message: Yes or No

If so, where: Home or Cell

May we email you: Yes or No

Marital Status

Social Security Number

Driver's License Number

Race

Ethnicity

Preferred Language Spoken

Emergency Contact Name

Relationship

Phone number

Employer's Name

Employer's Phone Number

Is this Worker's Comp? YES NO

Employer's Address

City

State

Zip

What is your occupation?

How long?

1.) Name of Insurance Company

ID Number

Policy Holder's Name

DOB for Policy Holder

Relationship to Patient

Policy Holder's Employer

Phone Number

2.) Name of Secondary Insurance Company

ID Number

Policy Holder's Name

DOB for Policy Holder

Relationship to Patient

Policy Holder's Employer

Phone Number

Signature: _____

Date: _____

PATIENT MEDICAL HISTORY/INFORMATION

Name: _____ DOB: _____

PCP/referring provider: _____ Chief complaint: _____

Do you have a history of:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Breast disease | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Pulmonary embolism |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Other: Please specify _____ | | | |

Family History (Please list): _____

Please List ALL of your previous surgeries:

<u>SURGERY</u>	<u>YEAR</u>	<u>SURGERY</u>	<u>YEAR</u>
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Last colonoscopy? _____ Last EGD? _____

Please list ALL current medications, dose, amt/day:

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Do you take any blood thinners (such as Coumadin, Plavix, Xarelto, Aspirin, etc...): _____

Please list your drug allergies: _____

Pharmacy Preference: _____

Location/Town: _____ Phone number: _____

Do you:

- | | |
|---|--|
| <input type="checkbox"/> Smoke? How long? _____ | <input type="checkbox"/> Have you ever smoked? How long? _____ |
| <input type="checkbox"/> Drink alcohol? How much? _____ | <input type="checkbox"/> Do drugs? What? _____ |
| <input type="checkbox"/> Diet pills? What kind? _____ | |

Have you recently had any of the following?

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Fever/Chills | <input type="checkbox"/> Seizure | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Heart palpitations |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Double vision | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Vision changes | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Leg swelling |
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Earache | <input type="checkbox"/> Constipation | <input type="checkbox"/> Edema |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Headache | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Nipple discharge |
| <input type="checkbox"/> Acid reflux/heart burn | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Abdominal mass | <input type="checkbox"/> Breast lump |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Painful joints | <input type="checkbox"/> Itching | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Change in mole |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Immune problems |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergy to iodine |

Sign: _____ **Date:** _____

PLEASE NOTIFY US IF ANY OF THE ABOVE INFORMATION CHANGES AT FUTURE VISITS.

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HIPAA PATIENT ACKNOWLEDGMENT FORM

In signing this HIPAA Patient Acknowledgment form, I acknowledge and authorize, that I hold harmless this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring from this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this Healthcare Facility is in actual receipt of a signed revocation or until the records retention period required under federal and state laws has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I may inspect a copy of my PHI to be used or disclosed under this authorization; that this Healthcare Facility has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization. A copy of this signed, dated authorization shall be as effective as the original.

Consent to release Protected Health Information (PHI)

I understand that in order to disclose my PHI, Rockwall Surgical Specialists must have my consent, therefore, I authorize Rockwall Surgical Specialists to disclose my PHI as described in the above forms, to the recipients listed below:

Description of the information to be disclosed (Check all that apply):

All procedures Test results Appointments Other Surgeries Billing/Account information

Name(s) of the person(s) authorized to obtain the abovementioned information. (e.g. Physician other than your referring doctor, family members and other specified person(s))

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize Rockwall Surgical Specialists to contact me at the with results or questions and acknowledge if I chose to have my information emailed there is a risk of breach.

Patient name: (Print and Sign) _____

Date: _____

Patient representative: (Print name and sign) _____

Relationship to patient: _____

Date: _____

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ASSIGNMENT OF BENEFITS

I consent for Dr. David Ritter, Dr. Ashley Egan, Dr. Jon Harris, Dr. Joshua Mark, and staff to render consultation and treatment. I understand that if I am a minor, a parent or legal guardian must be present at the time of consultation. I, the undersigned, certify that I or my dependent, have insurance coverage and that I have provided that information. I also understand that it is MY RESPONSIBILITY to keep the information updated. I understand there is the possibility that Out-of-Network Provider(s) may provide all or part of the Covered Services. You may contact your insurance company for more information. I assign directly to the above-mentioned physician all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize the physician to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for all procedures and others pay a percentage of the charges. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

If this account is assigned to an attorney for collections and/or suit, the practice shall be entitled to reasonable attorney fees and cost of collections. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health plans to the practice named on this form. The assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

In the course of your treatment from Dr. David Ritter, Dr. Ashley Egan, Dr. Jon Harris, or Dr. Joshua Mark, you may be referred to, or certain procedures may be performed at a facility that the physician may have a financial interest in. By signing this disclosure, you acknowledge the physician's possible financial interest in this facility and your election to use such facility. You are not required to use any of these facilities and have the option to use an alternative health care facility. Please let us know if you have any concerns regarding the relationship between the physician and facilities.

We would like to inform you that if you are required to have a surgical procedure or medical treatment by Dr. David Ritter, Dr. Ashley Egan, Dr. Jon Harris, or Dr. Joshua Mark the fees that are quoted to you from this office are for the services rendered by our office only. You will need to discuss laboratory, pathology, anesthesiology, and facility charges with those individuals. They each have a separate billing office and have NO AFFILIATION with our office. The amount you are requested to pay at the time of scheduling is an estimated amount, due to your insurance benefits. After the surgical procedure or medical services are performed, your insurance company will be billed. If there is any remaining balance that you are required to pay, you will receive a statement from our office with that amount on it. By signing this form, you acknowledge that you are responsible for any balances on your account and or any services not covered by your insurance company. I have read the above statement and agree that if my insurance company fails to pay, I accept responsibility for charges incurred.

I have read and understand the above disclosure.

PRINTED PATIENT NAME: _____

RESPONSIBLE PARTY SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____ DATE: _____

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FMLA/Short Term Disability Release of Information Authorization

I, _____, here by authorize Rockwall Surgical Specialists (physicians and staff) to release any information requested from my employer, human resource department, insurance company, or disability company that is in regards to my time off work request, family leave forms (FMLA), disability payments, or time off compensation.

I also understand that at any time I can revoke this authorization by submitting a request in writing. If I need to re-instate this authorization, I must sign a new form with a current date and this request must be presented in person (by the patient) for authenticity.

Printed name

Signature

Date

OFFICE LOCATIONS

PLEASE NOTE WE HAVE OFFICES IN 4 DIFFERENT LOCATIONS FOR YOUR CONVENIENCE. IF YOU HAVE QUESTIONS REGARDING WHERE YOUR OFFICE APPOINTMENT IS LOCATED PLEASE DON'T HESITATE TO CALL AND CONFIRM (972) 412-7700.

Rockwall

1005 W. Ralph Hall Pkwy
Suite 211
Rockwall, Texas 75032

Rowlett (*Behind Baylor Lake Pointe Hospital tower*)

6705 Heritage Pkwy
Suite 104
Rockwall, Texas 75087

Forney

763 Highway 80
Suite 130
Forney, Texas 75126

Greenville

4400 IH-30 West
Suite 300
Greenville, Texas 75402