Rafael A. Avila M.D., P.A.

PATIENT REGISTRATION FORM

PLEASE PRINT

Date: _____ Home Phone: _____

Cell Phone: _____

Patient's Information:

Last Name: _____ First: _____ Middle: _____

Address: _____ Driver's License #: _____

City: _____ State: _____ Zip: _____ Sex: ___F ____M

Age: _____ Birthday: _____ Marital Status: ___S ___M ___W ___D SS#: _____

Employer's Name: _____ Phone #: _____

Occupation: _____ Work #: _____

Spouse's Information: If under age Parent's Information:

Parent/Spouse Name: _____ Birthday: _____ SS#: _____

Employer's Name: _____ Phone #: _____ Driver's License#: _____

Purpose of Visit: _____

Primary Care Physician: _____ Phone #: _____

Primary Insurance

Do you have Insurance? __Y __N Is the Insurance under your name? __ Y __N (if no fill the following)

Subscriber's Name: _____ Relationship: _____

SS#: _____ Birthday: _____ Policy #: _____ Driver's License: _____

Please have insurance cards available for receptionist verification

Home Health Information: (If any)

Name: _____ Phone#: _____

In case of an emergency, **we must have a phone number other than "your" home or work.** We need a neighbor's, relative's, or friend's number:

Name: _____ Relationship: _____ Phone# : _____

ASSIGNMENT OF INSURANCE BENEFITS
CONCENT FOR TREATMENT

I authorize payment of insurance benefits otherwise payable to me directly to the doctor. I also consent to treatment by the health care providers of this medical practice. I also hereby authorize the release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits and/or to pay referring physician for purpose of treatment, payment, or operations. **I further acknowledge that in the event these services are denied as "not medically necessary" by Medicare or Medicaid programs and I requested these services be provided to me for my condition or illness, I accept responsibility for my payment. If I the patient or guardian of the patient is a self pay patient, I accept responsibility for the payments of the account**. I have read a copy of Privacy Notice and I was given an opportunity to object to disclosures of my protected health information.

I permit a copy of this authorization to be used in place of the original.

Patient signature: _____ **Date:** _____

(If under 18 parent/guardian signature)

1022 E. Griffin Parkway Suite 110, Mission Texas 78572 PH. (956) 529-1743 FAX (956) 519-3515

HEALTH HISTORY: COUTESY OF AVILA PLASTIC SURGERY

Date: _____ Name: _____
Age: _____ Height: _____ Weight: _____ lbs.

PLEASE ANSWER ALL OF THE QUESTIONS AS ACCURATELY AS POSSIBLE. IF YOU DO NOT UNDER STAND THE QUESTION, PLEASE ASK FOR ASSISTANCE.

Primary Care Doctor: _____ Phone #: _____
Cardiologist Doctor: _____ Phone #: _____

Drug Allergies: _____

List all medication you are taking, including non-prescription drugs, vitamins, herbals:

_____

Please indicate all Blood Thinners: _____
List any Surgery (including cosmetic):

_____

_____

FAMILY HISTORY:
Has any blood relative ever had the following?

Breast Cancer…..yes/no	High blood pressure…..yes/no	Kidney disease…….yes/no
Melanoma……..yes/no	Heart disease……yes/no	Depression……...yes/no
Stroke……..yes/no	Diabetes……yes/no	

PAST MEDICAL HISTORY:
Have you ever had the following?

Heart disease……..yes/no	Cancer……...yes/no	Stomach ulcer……..…yes/no	Any mental illness…..yes/no
Arthritis……yes/no	Glaucoma….yes/no	Kidney disease……....yes/no	If yes please specify:
Rheumatic fever…yes/no	Asthma…....yes/no	Thyroid disease……yes/no	_____
Anemia……..yes/no	AIDS/HIV..yes/no	Bleeding tendency……yes/no	_____
Tuberculosis…….yes/no	Stroke…….yes/no	Mitral valve prolapse……yes/no	_____
Diabetes……yes/no	Hepatitis….yes/no	High Blood pressure…yes/no	Name of Dr. treating you:
			_____

REVIEW OF SYSTEM:
Do you have now or have you had within the past year?

Weight change…..yes/no	Swollen feet/ankles…..yes/no	Seizures……..yes/no
Dry eyes……yes/no	Skin rash……..yes/no	Joint or muscle pain……yes/no
Chronic cough…..yes/no	Chronic Diarrhea…….yes/no	Swollen lymph nodes….yes/no
Chest pain…….yes/no	Jaundice……..yes/no	Easy Bleeding……..yes/no
Rapid heart beat…yes/no	Depression……yes/no	Easy Bruising……yes/no

Other: _____

WOMEN ONLY:
Age period began: ____ Number of pregnancies: _____(If applicable) Bra Size: _____
Date of last Mammogram: _____ Did you breast feed? Yes/ No
Do you do regular breast self-examinations? Yes/No Breast lump or discharge? Yes/No

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLWDGE.

_____

SIGNATURE OF PATIENT OR PARENT IF MINOR