Noel Lopez, M.D.
5140 N. 10th Street - McAllen, TX 785042834
Phone: (956) 972-1600 - Fax: (956) 972-0880

Patient Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security#: _____ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Cell Phone: _____ Work Phone: _____ **Mobile Carrier:** _____

Maiden Name: _____ Employment Status: ☐ Employed ☐ Part-time Student ☐ Full-time Student ☐ Other

Employment-Information

Employer: _____ Occupation: _____

Address: _____ (City, State, Zip): _____

Responsible Party Information

Name: _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security#: _____ Responsible Party's Phone#: _____ Relationship to Patient: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Social Security #- _____ Phone: _____

Insurance Company: _____ Group #- _____ ID Number: _____

Address: _____ (City, State, Zip): _____

Spouse information

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security _____ Employer: _____ Employer Phone: _____

Relative to Contact in Case of Emergency

Name: _____ Phone: _____ Relationship to Patient: _____

Address: _____ (City, State, Zip): _____

is Your Illness or Injury Related to Any of the Following?

☐ Employment ☐ Emergency ☐ Accident ☐ Auto Accident (State of Auto Accident) _____

If Employment related, has employer been notified? ☐ Yes ☐ No Employer Contact Name: _____

Employer Contact Phone Extension: _____

How were you referred to our office?

☐ By an Attorney ☐ By a Doctor ☐ By a Patient ☐ Yellow Pages ☐ Other

Please print the name of your _____

Consent to Treatment/Financial Responsibility and Assigment of Benefits

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination, and treatment.

I hereby assign, transfer, and set over to Noel Lopez, M.D. all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I certify that I have read this form and understand its contents.

Patient or Other Legally Authorized Person: _____ Date: _____

Date: _____ Social Security#: ___ - ___ - ____

Name: _____ Account #: _____

Date of Birth: _____ Email: _____

List and describe the reason for your visit:
Problem #1:
Problem #2:
Problem #3:

Social History:

Marital Status: ☐Single ☐Married ☐Widowed ☐Common Law

Occupation: _____

How many children do you have? ____

Do you live alone?: ☐Yes ☐No

List your drug **allergies:** _____

List all your **surgeries** or **operations:** _____

_____

Have you ever smoked? If so, how much? _____ Year quit? _____

Do you drink alcohol? If so, what type and how much? _____

Do you use illicit drugs? If so, please list? _____

Have you had any of the following? (circle)

Allergies	Diabetes	Kidney stones	Bleeding disorder	Glaucoma
Asthma	High blood pressure	Kidney failure	Thyroid disorder	Pneumonia
Emphysema	High cholesterol	Dialysis	Arthritis	TIA
Tuberculosis	Heart attack	Blood transfusion	Epilepsy	Cancer of_____
Angina	Stroke	Hepatitis	Alcoholism	Suicide attempt
Gout	Depression	Ulcers	Drug abuse	

Other illnesses: _____

Do any of the following illnesses run in your family? (circle)

Asthma	Diabetes	Bleeding disorder	Prostate cancer
Emphysema	High blood pressure	Thyroid disorder	Breast cancer
Tuberculosis	High cholesterol	Arthritis	Lung cancer
Gout	Heart attack	Epilepsy	Colon cancer
Kidney stones	Stroke	Alcoholism	Suicide attempt
Ulcers	Depression	Drug abuse	

List all your medications: _____

_____

_____

_____

_____

_____

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Insurance is a way for you to receive repayment for fees you have paid to a physician for services rendered. Having insurance is not a substitute for payment. Even though insurance companies have a fixed allowance or percentage based on your policy with them, your policy is with your insurance company, not with this office. It is your responsibility to provide payment for the deductible, co-insurance, and any other balances not paid for by your insurance. We will assist you in receiving reimbursement in any way possible, but you are ultimately responsible for the payment of your bill.

Primary Insurance: _____ Effective Date: _____

Address: _____ City/State/Zip: _____

Policy #- _____ Group #- _____ Phone #, _____ ___

insured: _____ Relationship to Insured: _____

Secondary Company: _____ Effective Date: _____

Address: _____ City/State/Zip: _____

Policy #- _____ Group #* _____ Phone #* _____

insured: _____ Relationship to Insured: _____

Medicare Patients

I request that payment of authorized Medicare benefits be made to me or on my behalf to Noel Lopez, M.D. for any services furnished me by Noel Lopez M.D. I authorize that any holder of medical records about me to release to the Health Care Financing Administration and its agents any information necessary to determine benefits and process the insurance claim. This agreement will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

Non-Medicare Patients

I authorize the release of all medical records needed to process this claim and that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, to Noel Lopez, M.D. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I ASSUME FINANCIAL RESPONSIBILITY FOR ALL CHARGES. I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND IT.

Patient:

_____ _____

(if patient is a minor, a parent's signature is required) (responsible party)

_____ _____

(witness) (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

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority