Las Cruces Surgeons Group

925 S. Walnut, Las Cruces, NM 88001
575-523-6330

PATIENT REGISTRATION FORM

Birthday:

Patient's Legal Name:

Marital Status (circle): Single / Married / Divorced / Separated / Widowed

Who lives at home with you?

Mailing Address **Phone Number:**

City: **State:** **Zip:**

Occupation:

Medical diagnoses:

Prescription Medications:

Past Hospitalizations/Surgeries:

Drug Allergies:

Do you smoke? NO YES Packs per day:

Do you drink? NO YES Drinks per week:

Signature: **Date:**

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Medical History: Please check any conditions that are a SIGNIFICANT problem for you.

General	YES	Cardiovascular	YES	Genitourinary	YES
Fever or chills		Chest pain with activity		Burning or painful urination	
Recent weight change		Hear skips beats		Frequent urination	
Fatigue		Heart beats too fast		Blood in urine	
Heat or cold intolerance		Passing out spells		Bladder infections	
Head and Neck	**YES**	High blood pressure		Incontinence or dribbling	
Swelling in neck		Heart murmur		Kidney Stones	
Prolonged hoarseness		Bad heart valve		Change in stream	
Sore throat		Rheumatic fever		Irregular menses	
Pain or stiffness in neck		Feet or ankle swelling		**Gastrointestinal**	**YES**
Skin	**YES**	Short of breath at rest		Rectal bleeding	
Rash, dryness itching		Short of breath with exercise		Blood in stool	
Change in nails or skin color		Short of breath lying down		Loss of appetite	
Bleeding, bruising tendencies		**Lungs**	**YES**	Heartburn or indigestion	
Eyes	**YES**	Cough		Chronic abdominal pain	
Glasses or contacts		Cough with sputum or blood		Chronic constipation	
Double, failing vision		Wheezing		Black or tarry stools	
Dry eyes		**Musculoskeletal**	**YES**	Frequent diarrhea	
Pain or light sensitivity		Swollen or red joints		Difficulty swallowing	
Ears, Nose, Mouth		Arm or leg weakness		Nausea or vomiting	
Loss of smell		Leg Cramps		Vomiting of blood	
Nose Bleeds		Difficulty in walking		**Endocrine**	**YES**
Sinus problems		**Neurologic**	**YES**	Night sweats	
Runny Nose		Lightheaded or dizziness		Excessive thirst	
Postnasal drip		Speech disturbances		**Psychiatric**	**YES**
Earache or drainage		Convulsions or seizures		Depression	
Hearing loss		Numbness or tingling		Anxiety	
Ringing in ears		Frequent headaches		Nervous breakdown	
Dentures		Memory loss		Alcohol problems	
Sores in mouth		Paralysis or weakness		Physical, verbal, sexual abuse	
		Sleep disorders		Drug Problems	

Past and Family History: Please check if you or your family have ever had any of the following

	You	Family		You	Family		You	Family
Hypertension			Irritable Bowel			Rheumatoid Arthritis		
Heart Disease			Jaundice			Thyroid Disease		
Stomach Ulcers			Blood Clots			Rheumatic Fever		
Seizure/Epilepsy			Depression			Liver Disease/Hepatitis		
Diabetes			Tuberculosis			Breathing Problems		
Cancer			Blood Disorders			Vision Problems		
Renal Disease			Lupus			Hearing Problems		
Ulcerative Colitis			Stroke			Glaucoma		
Other			Other					

CANCER TYPE: ______________________________________

Signature: ____ **Date:** ______________________

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INSURANCE INFORMATION

Please provide insurance card and ID

Person Responsible for bill:	Date of Birth:	Address (if different):
Primary Insurance:	Subscriber Name:	Subscriber Social Security:
Policy Number:	Group Number:	Subscriber DOB:
Patient Relationship to Subscriber: Self / Spouse / Child / Other	Is this patient covered by Insurance? YES / NO	Copayment:
Secondary Insurance:	Subscriber Name:	Subscriber Social Security:
Policy Number:	Group Number:	Subscriber DOB:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to Patient:	Emergency Contact Phone:

PLEASE READ AND SIGN

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Dr. Paul Cooney. I understand that I am financially responsible for any balance. I also authorize Vein and Skin Treatment Center or company to release any information required to process my claims.

______________________________________ ____________________________

Patient/Guardian Signature **Date**

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Name: ____ DOB: _________________________

What is your reason to visit the doctor today?

____

Please circle or fill in the blanks:

Location:
Where is the problem? Hemorrhoids Lump Skin Breast Mass Legs Veins
Other: ____

Duration:
How long has the problem been there?

_____Days _____Weeks _____Months _____Years

Severity:
MINOR MODERATE SEVERE
On a scale of 1-10, 10 being the highest, how would you rate yours?

1 2 3 4 5 6 7 8 9 10

Quality:
Describe the quality of your symptoms: Sharp Dull Burning Throbbing

Context:
How did the symptoms begin? Gradually Over-Time Suddenly

Modifying Factors:
What makes it better? Medication Heat Ice Rest Elevation Compression

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Associated Symptoms:
Are there any other signs or symptoms associated with your main problem?

____

How did you hear about us? ____

Do you take any blood thinners? (Coumadin, Eliquis, Plavix, etc.) _____________

Vein History

What is the reason you're seeking treatment? ________________________________

Have you ever worn compression stockings? ______________________________

Have you ever had a blood clot? ____

If yes, please describe when and where:
____

Do you experience any of these symptoms in your legs? (Circle)

Aching/Pain   Leg Cramps   Ulcer   Bleeding

Heaviness   Tiredness   Throbbing   Tiredness

Restless Legs   Itching   Burning   Discoloration   Swelling

Are the Symptoms on the: Right   Left   Both Legs?

Do you have problems walking?   Yes   No

Please Explain: ____

Are your symptoms worse at the end of the day?   Yes   No

Are the symptoms in your legs interfering with your work or life?   Yes   No

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that the information will be used to:

> **Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly or indirectly.**
> **Obtain payment from third-party payers.**
> **Conduct normal healthcare operations such as quality assessments and physician certifications.**

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address listed above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature of Patient: ____ **Date:** _____________________

Disclosure Statement

The patient-physician relationship is one of trust. It is vital that all patients disclose their entire medical history. This includes all surgeries, including cosmetic procedures. The disclosure of your entire medical history is done to allow us to make a more suitable decision regarding your treatment. Failing to disclose all prior surgeries increases many potential risks including DVT (deep-vein thrombosis), bleeding, infection, and death.

It is pertinent to your health that your ENTIRE medical history be disclosed prior to seeing the physician. Please remember any information obtained by this office will be kept confidential and will be released only upon obtaining your written permission.

I have read and understand the Disclosure Statement and have fully disclosed my medical and surgical history.

Printed Name: ____

Signature: ____ **Date:** __________________________

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AUTHORIZATION TO LEAVE MESSAGE

I hereby authorize my physician's office to leave a message to discuss or release information regarding pending appointments and/or test results at my residence either on answering machine, voicemail, email, at home, office, or with any family members or designees listed below: (initial please)

______ **I DO authorize the following:** ______________________ ________________ ________

Name/Relationship Phone Number Date

______ **I authorize only appointment messages to be left with anyone at my designated phone number, including on the answering machine.**

______ **I DO NOT authorize release of any information to anyone other than myself.**

MEDICARE PATIENTS ONLY

Medicare requires that all Medicare patients read and sign the following before we can file your claim:

I request that payment of authorized Medicare benefits be made on my behalf to Las Cruces Surgeons Group for any services furnished to me by the physician. (Services denied by the Medicare Program as non-covered will be billed to you.)

I authorize the release of medical information about me to be released to the Health Care Financing Administration (HCFA) and its agent and to my insurance company to determine the benefits payable for related services.

____ ____________________

Signature of Medicare Recipient Date

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MISSED APPOINTMENT POLICY

Our goal is to provide quality individualized medical care in a timely manner. No-shows, late shows, and cancellations inconvenience those people who need access to medical care. We would like to remind you of our policy regarding missed appointments.

Cancellation of an Appointment

To be respectful of the medical needs of other patients, please be courteous and call the office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who needs the treatment. If it is necessary to cancel your scheduled appointment, we require you call at least 24 hours in advance.

How to Cancel Your Appointment

To cancel, call 575-523-6330. If you do not reach the receptionist, you may leave a message on our voicemail. If you would like to reschedule your appointment, please leave your name and phone number.

Late Cancellations: A cancellation is late when the appointment is cancelled without a 24-hour notice and is subject to a $50 fee for non-cancellation in the appropriate time.

NO SHOW: A no-show is a patent who misses an appointment without cancelling it. A failure to present at time of visit will be recorded as a no-show 15 minutes after your scheduled appointment.

____ ____________________

Sign **Date**

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Patient Financial Responsibility Agreement

I, ____, have retained Las Cruces Surgeons Group, LLC, Lone Star Surgeons Group, LLC, Vein & Skin Treatment Center to provide various medical and surgical services to myself. I understand that the office will bill my insurance company, gain prior authorizations, and further bill me for all charges incurred.

I further understand that when an insurance company authorizes a procedure or informs you that you are not required to obtain authorization, there still is no guarantee for payment from the insurance company.

I understand that I am fully responsible for services rendered. I further understand that once the office has exhausted all efforts to collect funds from the insurance company, that I will receive a bill. This bill will reflect the services and dates rendered.

By signing this form, I am stating that I have been informed that providing an insurance card at the time of service is not a guarantee that my insurance will cover the services. I also am stating that I am aware that I could be responsible for the total amount of the bill. I further understand, there are no refunds for medical and surgical services rendered.

Printed Name: ____________________________________ **Date:** ________________

Signature: ____