17177 Preston Rd STE 180
Dallas Tx 75248

Patient Registration Form
(Please print or write legibly)

Last Name: _____ First: _____ MI: _____

Gender: ☐ Male ☐ Female Date of Birth: _____ Social Security: _____

Mailing Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Please check your preferred primary phone number:

☐ Home: _____ ☐ State: _____ ☐ Mobile : _____

Email : _____ Preferred Language: _____

Marital Status: _____ Race/ Ethnicity: _____

Emergency Contact: _____ Relationship: _____

Primary Number: _____ Secondary Number: _____

Primary Physician : _____ Phone Number: _____

Do you see any other specialists? If so, please list contact information: _____

_____

INSURANCE INFORMATION

Insurance card(s) or proof of insurance must be presented at time of service.

Primary Insurance: _____ Policy Number: _____

Group Number: _____ Insured Name: _____

Relationship to Insured: _____ DOB of Insured: _____

Secondary Insurance: _____ Policy Number: _____

Authorization to Release Medical Records

Patient Information : (Please Print)

Name: _____
Date of Birth: _____ Social Security Number: _____
Address: _____
City/State/Zip: _____
Phone Number: _____

I hereby authorize: (Office Use Only)

Name: _____
Address: _____
City/State/Zip: _____

To disclose the following specific medical information by mail or fax to:

DFW SURGICAL PARTNERS
17177 Preston Rd STE 180 Dallas Tx 75248
Office: (214) 810-7408 Fax: (214) 810-7391

My authorization extends to the following items below:

Progress Notes	Operative Notes
History and Physical	Consults
Lab Reports	MRI/ABI Reports
Echo/EKG/Stress Test	Diagnostic Testing

This authorization is given freely with the understanding that:

- All records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my authorization, except as otherwise provided by law.
- A photocopy or fax of this authorization is as valid as the original.
- I may revoke this authorization at any time except where information has already been released. This authorization is valid for a one year period from the date that it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.
- Information used to disclose pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

Patient Name: _____ Patient Signature: _____
Patient's Representative: _____ Date: _____
Witness: _____ Date:_____

Medical History

Patient Name: _____ Date: _____

Past Medical History-Check all that apply:

__ Aortic Aneurysm
__ Alzheimer/ Dementia
__ Anemia
__ Angina
__ Arrhythmia (i.e: A-Fib)
__ Asthma
__Cardiomyopathy
__Anxiety/Panic Attacks
__ Arthritis
__ Blood clots in veins/lungs
__ COPD/Emphysema
__ Menopause
__ Heart Failure
__ Clotting/Bleeding Disorder
__ Coronary Artery Disease
__ Diabetes
__ Heart Murmur
__ High Blood Pressure
__ Depression
__ Vericose/Spider Veins
__ Bronchitis/Pneumonia
__ HIV/AIDS
__ Cirrhosis/Hepatitis Type: ___
__ Other: _____
__ Kidney disease stage: ____
__Heart attack *when*: _____
__ Peripheral arterial disease
__ Sleep Apnea
__ Stroke/TIA
__ Thyroid disease
__ Epilepsy/Seizures
__ Phlebitis/Swelling/Celluilis
__ Rheumatic fever
__ Acid reflux/stomach ulcers
__ Tuberculosis

Surgical History-Check all that apply:

__ Appendectomy
__ Carpal tunnel release
__ Cataract/ Glaucoma
__ C- Section
__ CABG
__ Cardiac/Vascular Stent
__ IVC Filter
__ Fracture Repair
__ Gall Bladder
__ Hip Replacement
__ Hysterectomy/Tubal ligation
__ Pacemaker/AICD
__ Carotid artery repair
__ Hernia Repair
__ Knee Replacement
__ Blood transfusion
__ Tonsil/adenoids
__ Back/Neck
__ Heart valve replacement
__ Gastric bypass
__ Other: _____

Past Hospitalizations: _____
_____
_____

Confidential Health History

Name: _____ Date: _____

Advance Directive in Place: ☐ Yes ☐ No If yes, please provide a copy.

Family Medical History (Check if yes)

Father:	___ Living?	___ Heart Disease?	___ Stroke?	___ Other? _____
Mother:	___ Living?	___ Heart Disease?	___ Stroke?	___ Other? _____
Grandfather:	___ Living?	___ Heart Disease?	___ Stroke?	___ Other? _____
Grandmother:	___ Living?	___ Heart Disease?	___ Stroke?	___ Other? _____
Brother/Sister:	___ Living?	___ Heart Disease?	___ Stroke?	___ Other? _____

Social History

Tobacco Use: ___ Never ___ Quit Date:_____
Do you Smoke: ___ Pipe ___Cigar ___ Cigarette ___ Chewing Tobacco ___ E-Cigarette
If you are a smoker, how many packs/day? _____
How long have you smoked? _____

Do you drink alcohol? ___ Yes ___ Formerly ___Never
Type: ___ Beer ___ Wine ___ Liquor
How often? (Drinks/day) _____

Allergies

Are you allergic to any medications? ____ Yes ___ No
If yes, please list: _____
Have you had a reaction to X-Ray contract dye? ___ Yes ___ No
Are you allergic to iodine or shellfish? ___ Yes ___ No
Are you allergic to Latex? ___ Yes ___No

Medication List

Patient Name: _____ DOB: _____

Please include all prescription and over the counter medication, including herbal products and vitamins.

Medication	Dose	Quantity/Frequency

Pharmacy Name: _____

Pharmacy Address: _____

City/State/Zip Code: _____

Phone Number: _____

Patient Name: _____

Patient Signature: _____

PATIENT HIPPA ACKNOWLEDGMENT AND CONSENT FORM

Patient Name: _____ Date of Birth: _____

Notice of Privacy Practices

I acknowledge that I have received the practice's Notice of Privacy Practice, which describes the way in which the practice may use and disclose my healthcare information for its treatment, payment healthcare operations, and other described and permitted uses and disclosures. I understand that his information may be disclosed electronically by the provider and/or the provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purpose described in the practice's Notice of Privacy Practices.

Release of Information

I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission (s) at other DFW SURGICAL affiliated facilities may be made available to subsequent DFW SURGICAL affiliated facilitated to coordinate patient are for the case management purposes. Healthcare information may release to any person or entity liable for payment on the Patient's behalf to verify coverage or payment questions, or for any other purpose related to benefits payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carries for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information my include, without limitation, history and physical, emergency records, laboratory reports, operative report, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions, and/or infectious diseases including but not limited to, blood borne diseases, such as HIV and AIDS.

Assignment and Authorization of Benefits for Patients with Insurance

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, and other plans DFW SURGICAL PARTNERS. I understand that I am financially responsible for all charges, co-payment, co-insurance, and deductible. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical records. I authorize insurance claims filed and benefits assigned.

Financial Acknowledgement for Private Pay Patients or Patients without Insurance

Patients who do not have insurance coverage are expected to pay charges in full at the time services are rendered. I agree that I am financially responsible for all charges incurred during the time of service.

Our HIPPA Acknowledgement form provides information about how we may use and disclose protected health information about you. You have the right to review our Form before signing this consent. As outlined in our Form, the terms our Form may change. If our Form is changed or modified, you may obtain a revised copy by requesting form the receptionist.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment , or health care options. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

Patient Signature: _____

Print Full Name: _____

Date: _____

Legally Authorized Individual signature: _____

Date: _____

Patient Consent Form

General Consent for Care and Treatment

TO THE PATIENT: You have the right as a patient to be recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risk and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure or any identified condition(s). The consent will remain fully effective until it is revoked in writing.

This consent provides us with permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. And (2) you consent to treatment at this office or any other satellite office under common ownership. You have the right to discuss the treatment plan with a physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions. You have the right at any time to discontinue services. I voluntarily request Dr. _____and/or other healthcare provider or the designees as deemed necessary to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at DFW SURGICAL PARTNERS . I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I acknowledge that I have read and fully understand the above statements and consent to fully voluntarily to its contents.

Print Name: _____

Signature of patient: _____

Date: _____

Patient Rights and Responsibilities

DFW SURGICAL PARTNERS and medical staff have adopted the following statement of patient rights. These rights are explained to the patient or the patient's representative.

These rights shall include, but not be limited to, the patient's right to:

- Patients are treated with respect, consideration, dignity and provided appropriate personal privacy.
- Patient disclosures and records are treated confidentially, and patients are given the opportunity to approve or refuse the release, except when release is required by law.
- Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment and prognosis.
- When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
- Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.
- Patients have the right to the facility's rules and regulations as they apply to their conduct, responsibilities and participation as a patient.
- The patient has the right to change their provider if other qualified providers are available.
- Be fully informed of the scope of services available at the facility, provisions for after-hours and emergency care, and related fees for services rendered.
- Be informed of charges, fees for service, payment policies, receive an explanation of your bill and receive counseling on the availability of known financial resources for health care services.
- Be informed of your right to refuse to participate in experimental research if applicable.
- Know that, in the event that a patient has an advance directive, it is the policy of This Center resuscitate all patients; however, any advance directive will be noted in the patient medical record and will be communicated to other medical facilities, if a transfer is needed.
- The patient has the right to receive enough information from the physician so that he/she can understand the services being rendered to sign the informed consent.
- The patient may leave this facility, even against the advice of his or her physicians.

- Reasonable continuity of care and advance knowledge of the time and location of appointment, as well as knowledge of the physician providing the care.
- Be free from all forms of abuse, discrimination, harassment or reprisal. Receives access to equal medical treatment and accommodations regardless of race, creed, sex, national origin, religion, or sources of payment for care.
- Know that your physician may have financial interests or ownership in this facility.
- Know the name and role of your caregiver (e.g., doctor, nurse, technician, etc.).
- You have a right to request information, malpractice insurance coverage and/or credentials about the physician providing your care.
- Report any comments or voice any grievances concerning the quality of services provided to the patient during the time spent at the facility without being subjected to discrimination or reprisal and receive timely, fair follow-up on your comments. Marketing or advertising regarding the competence and capabilities of the organization is not misleading to patients.

For complaints or comments about your medical care, you may call or contact:

State Department of Health Services 512-776-7111

PO Box 14937 Austin Tx, 78714-9347

Medicare Beneficiary Ombudsman: www. www.cms.hhs.gov/center/ombudsman

Patient Responsibilities:

As a patient in our center, you have certain responsibilities which include:

- Provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements

and any allergies or sensitivities.

- Follow the treatment plan prescribed by his/her provider.
- Provide a responsible adult to transport him/her home from DFW SURGICAL PARTNERS and remain with him/her for 24 hours required by his/her provider.
- Inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.
- Accept personal financial responsibility for any charges not covered by his/her insurance.
- Be respectful of all the health care providers and staff, as well as other patients.
- Respect the privacy of other patients.
- To work with your health care team and to follow all safety rules.

- To tell your doctor about any changes in your health after you leave our center.
- To keep, or cancel in a timely manner, your scheduled appointments for your health care.
- To tell your health care team if you wish to change any of your decisions.
- To ask for clarification if you do not understand any information or instructions given to you by your health care team.

IF YOU HAVE CONCERNS:

If you have any questions or concerns about your responsibilities, you can contact our administrator.

Coleman Fiihr: cfiihr@dfwsurgicalpartners.com

File a grievance with the facility by contacting the Medical Director, via telephone or in writing, when you feel your rights have been violated. See grievance policy.

Dr. Mohammad Nawaz: drzaim@sbcglobal.net

If you wish to file a complaint about your care in our facility you may contact the following agency:

State Department of Health Services 512-776-7111

PO Box 14937 Austin Tx, 78714-9347

Medicare Beneficiary Ombudsman: www.cms.hhs.gov/center/ombudsman

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____