COLLIN COUNTY SURGEONS
PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

Patient's Name: (Last) _____ (First) _____ (MI) _____

Address: _____

City, State, Zip: _____

Home: _____ Cell: _____ Work: _____

E-Mail Address: _____ DOB: _____

Sex: ☐ Female ☐ Male ☐ Transgender

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Language: ☐ English ☐ Spanish ☐ Indian: Hindi, etc. ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Social Security Number: _____ - _____- _____

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐

Responsible party name: (Last) _____ (First) _____ (MI) _____

Date of birth: MM _____/DD _____/YYYY_____ Sex: ☐ Female ☐ Male

Social Security Number: _____-_____-_____ Phone number: _____

Address: _____

City, State: _____ ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last) _____ (First) _____

Phone number: _____ Do you have a living will? ☐ Yes ☐ No

Emergency contact relationship to patient: _____ ☐ Guardian

Address _____

City, State: _____ ZIP: _____

Home phone: _____ Work hone: _____ Ext. _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks 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 for any identified condition(s).

This consent provides us with your 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. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers 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 this practice. 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 certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: _____ Date: _____

Printed name of patient or personal representative: _____ Relationship to patient: _____

COLLIN COUNTY SURGEONS
Medical History

Name: _____ Date of birth: _____ Height: _____ Weight: _____

Current Medications	Dosage

Previous Surgery	Date

Are you allergic to any medications? Yes or No (If yes, please list.)

Drug	Reaction

Have you ever had any of the following? Circle all that apply: High Blood Pressure, Diabetes, Heart problems, Irregular heartbeat, Heart failure, Pneumonia, Chronic cough, History of Stroke, Headaches, Heartburn, Bowel disorders, IBS, Constipation, Diarrhea, Hemorrhoids, Hepatitis, Rectal bleeding, Kidney disease, Kidney stones, Bladder problems, Prostate, Incontinence of urine, Blood in urine, Thyroid disease, Lung disease, Asthma, COPD, Jaundice, Liver, Gout, Breast cancer, Leukemia/Lymphoma, Tuberculosis, Psychiatric Disorder, Depression, Anxiety, Alcoholism, Anemia, Transfusions, Immune disease or HIV, Skin Disease, Joint Disease, Epilepsy-Seizures, Blood Clot ,

Do you smoke? Yes No or Never If yes, how many packs per day? _____

Do you use alcohol? Yes No If yes, how many drinks per week? _____

Do you or have you used the following in the last three months? Marijuana Cocaine Heroin Crack Methamphetamine

Family History (Please circle)
Mother: Alive / Deceased Father: Alive / Deceased

Is there any history of the following medical conditions in your family? Please circle.

Heart disease Lung disease Bowel disease Kidney disease Diabetes Hypertension Cancer

Date of last Flu shot:_____
Date of last pneumococcal shot:_____

Primary Care Physician:_____

Pharmacy information:

Name: _____ Phone number: _____

Address: _____

COLLIN COUNTY SURGEONS

Patient name: _____

Date of birth: _____

Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, Collin County Surgeons may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge Collin County Surgeons may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to Collin County Surgeons any insurance or other third-party benefits available for health care services provided to me. I understand Collin County Surgeons has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Collin County Surgeons, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Collin County Surgeons by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for Collin County Surgeons, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Collin County Surgeons or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Collin County Surgeons or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: _____ Date: _____

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

☐Spouse
☐Parent
☐Legal Guardian
☐Guarantor
☐Healthcare Power of Attorney
☐Other (please specify) _____