DEAN SMITH, MD, PA
PATIENT INFORMATION SHEET

PATIENT INFO

Patient Name (Nombre) | Today's Date (Fecha de Hoy)

Age (Edad) | SS No. (No.de Seguro Social) | Date of Birth (Fecha de Nacimiento)

Address (Direccion) | City, State Zip (Cuidad-Estado-Codigo Postal)

Employer (Empleo del Paciente) | Occupation (Occupacion)

Home Phone (Numero de Telefono de Casa) | Work Phone (Numero de Telefono du su Trabajo) | Cell Phone (Numero de Telefono de Cellular)

Emergency Contact (Contacto de Emergencia) | Relationship (Relacion del Paciente) | Phone (Numero de Telefono de Contacto de Emergencia)

Referred By (Quien fue su Referencia al Medico) | Address (Dirreccion de Referencia) | Phone (Numero de Telefono de Referencia)

GUARANTOR

(Person responsible for the bill)

Guarantor Name (Nombre de su Conyuge) | Date of Birth (Fecha de Nacimiento)

Age (Edad) | SS No. (No.de Seguro Social) | TDL# (No de Licencia Valida Para Manejar en el Estado Texas)

Spouse/Parent/Employer (Empleo del Paciente) | Occupation (Occupacion)

Home Phone (Numero de Telefono de Casa) | Work Phone (Numero de Telefono du su Trabajo)

INSURANCE

Primary Insurance (Primer Compania de Seguro Medico) | Primary Holder Name (Nombre Primer)

Policy # or ID # (Numero de Certificado o numero de identificacion) | Group # (Numero de Grupo)

Claims Address (Direccion de Correro) | Phone (Telephono)

Secondary Insurance (Segunda Compania de Seguro Medico) | Secondary Holder Name (Nombre Sequnda)

Policy # or ID # (Numero de Certificado o numero de identificacion) | Group # (Numero de Grupo)

Claims Address (Direccion de Correro) | Phone (Telephono)

Signature | Date

Relationship (if not signed by patient)

DEAN SMITH, MD, PA
MEDICAL HISTORY

Name: ______________________________ **Date of birth:** __________ **Today's Date:** ____________

ALLERGIES to medication: ☐ None ____

Current **Medications**: 1.____________________ 2.______________________ 3.____________________
4.____________________ 5.______________________ 6.____________________

PAST MEDICAL HISTORY:

	Yes	No		Yes	No		Yes	No
High blood pressure	☐	☐	Asthma	☐	☐	Reflux/ Gastritis	☐	☐
Heart attack	☐	☐	Chronic bronchitis	☐	☐	Stomach ulcers	☐	☐
Abnormal heart valve	☐	☐	Emphysema	☐	☐	Hepatitis Type: ______	☐	☐
Stroke	☐	☐	Diabetes	☐	☐	HIV +/ AIDS	☐	☐
Seizure disorder	☐	☐	Thyroid disorder	☐	☐			

Other: ____

PAST SURGICAL HISTORY

List any previous **Surgeries** you have had: ☐ None ____

____

FAMILY HISTORY

Do you have a family history of?

☐ Heart disease ☐ Stroke ☐ Cancer ☐ Arthritis ☐ Diabetes ☐ None

SOCIAL HISTORY

Adult Issues

Occupation: ____________________________________

Marital status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widow(er)

Pediatric/Adolescent Issues

Grade in school: ____________________ Name of school: ________________________________

Parent's marital status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widow(er)

TOBACCO/ALCOHOL/SUPPLEMENTS

Do you smoke? ☐ Yes ☐ No How many packs a day? ________ How many years? ________

Do you drink alcohol? ☐ No ☐ Socially ☐ Moderately ☐ Excessively

DEAN SMITH, MD, PA
NEW PROBLEM QUESTIONNAIRE

Name: ______________________________ **Date of birth:** __________ **Today's Date:** ____________

Please Answer ALL questions:

Chief Complaint (MAIN symptom):

☐ Pain ☐ Stiffness ☐ Numbness/tingling ☐ Swelling ☐ Mass
☐ Wound ☐ Deformity ☐ Weakness ☐ Lesion

Severity: ☐ Mild ☐ Moderate ☐ Severe
Involved side: ☐ Right ☐ Left ☐ Both
Involved area: ☐ Neck ☐ Shoulder ☐ Arm ☐ Elbow ☐ Forearm ☐ Wrist
☐ Hand ☐ Thumb ☐ Index ☐ Long ☐ Ring ☐ Small
Which hand do you write with? ☐ Right ☐ Left ☐ Both

When did your symptoms begin (date of injury)? _____/_____/_____ (exact date if possible)
How did it happen? ____
____
____

Associated Symptoms:
☐ Pain ☐ Stiffness ☐ Numbness/tingling ☐ Swelling ☐ Mass
☐ Wound ☐ Deformity ☐ Weakness ☐ Lesion

Symptoms occur:
☐ with activity ☐ after activity ☐ in the morning ☐ in the evening ☐ at night
☐ constantly ☐ intermittently ☐ with computer use ☐ at work

Feels:
☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching
☐ Cramping ☐ Tingling ☐ Burning ☐ Tearing

Treatment so far:
☐ Rest ☐ Ice/heat ☐ Splint/Cast ☐ Therapy ☐ Surgery ☐ None

Previous tests for this problem:
☐ Nerve study ☐ MRI ☐ None

DEAN SMITH, MD, PA
FINANCIAL POLICY

FINANCIAL RESPONSIBILITY

It is the policy of Dean Smith, MD, PA to bill your insurance carrier as a courtesy to you, even though you may be considered responsible for the entire bill when the services are rendered. If your insurance carrier does not remit payment within 60 days, the applicable balance will then be due in full from you. Unless your insurance company has a contract with Dean Smith, MD, PA to pay based on a specific negotiated fee schedule; you may be held responsible for any difference remaining between the insurance payment and the total charges.

We also require that arrangements for payments of your estimated share be made today. If any payment is subsequently made by your insurance carrier in the excess of the balance of your account, we will promptly refund the credit. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to Dean Smith, MD, PA.

However, if you are an HMO enrollee, the above statement only applies to your applicable co-pay and/or any other non-covered charge that you have agreed to be responsible for in advance of treatment. If you are a Workers' Compensation patient, you will only be held responsible for your charges in the event your claim is converted (not approved by either your employer or insurance company).

You understand and agree that if you fail to make any of the payments for which you are responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Dean Smith, MD, PA, you will be responsible for all cost of collecting monies owed including court cost, collecting agency fees and attorney fees. You also understand that you are responsible for keeping Dean Smith, MD, PA advised of any address change. If any correspondence is returned, you understand that the account will be considered in default and will be turned over for collection immediately.

The above information has been read and your signature on this form signifies that you understand your responsibilities for the payment of your account.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Dean Smith, MD for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dean Smith, MD to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Dean Smith, MD on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

______________________________	______________________________
Patient Name (Print)	Patient Date of Birth
______________________________	______________________________
Patient/Responsible Party Signature	Date
______________________________	______________________________
Witness	Date

DEAN SMITH, MD, PA

CONSENT FOR MEDICAL TREATMENT

I, the undersigned, as the patient (or the patient's duly authorized representative) do hereby voluntarily consent to and authorize medical care encompassing all diagnostic and therapeutic treatments and transfers to other facilities considered necessary or advisable in the judgment of the attending physician, his/her assistants or designee. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations performed in this facility. I authorize Dean Smith, MD, PA or members of its attending staff to retain me and I certify by my signature that I understand and accept its contents, except as noted.

Patient Name (Print)	Patient Date of Birth
Patient/Responsible Party Signature	Date
Witness	Date

ACKNOWLEDGE MENT 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.

Patient Name (Print)	Patient Date of Birth
Patient/Responsible Party Signature	Date
Witness	Date

Internal Use Only

If the patient/patient's representative refuses to sign this acknowledgement, please document date and time the Notice of Privacy Practices were presented to the patient and sign below.

Presented (date and time): ______________________________ By (name/title): _______________________________