PSMD Medical Associates PA
3132 Matlock Rd #311, Arlington, TX 76015
PH: (817) 987-1414 Fax: (817) 987-1425

Name:
Age:
DOB:

Registration Form

PATIENT INFORMATION			
Patient's Last name	First	Middle	Sex
Date of Birth	Social Security Number	Race	
Street Address	City	State	Zip code
Home Phone	Cell Number	Work Phone	
Email	Emergency Contact Name	Emergency Contact Phone Number	
Employer Name and Address		Employer Phone Number	

INSURANCE INFORMATION		
Insured Name	Date of Birth	Relationship
Primary Insurance	Subscriber No	Group No
Secondary Insurance	Subscriber No	Group No
Tertiary Insurance	Subscriber No	Group No

IN CASE OF EMERGENCY			
Name of friend or relative (not living at same address)	Relationship to patient	Home phone	Work phone

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize PSMD Medical Associates PA or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature **Date**

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In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPPA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

Please circle your response to the following:

YES NO N/A May we leave messages concerning your **appointments** with a co-worker, receptionist or secretary that regularly answer your calls?
YES NO N/A May we leave a **message** on a voice mail at work?
YES NO N/A May we discuss your **appointment/treatment** with your spouse?
YES NO N/A If you are over the age of 18, still living at home, may we Discuss your **appointments/treatments** with your parent(s) or guardian(s)?

You must inform us, in writing of any changes in your directives. This record takes effect on the date you sign below and will be kept in your file along with your acknowledgement of receipt of your Notice of Privacy Practices.

Signature: _____ Date: _____

Please list below the names and phone numbers of friends and/or relatives that you wish to relay medical as well as billing information to. Please state below if you deny this request.

_____
_____
_____
_____
_____

Financial Responsibility Agreement

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any Medical service or visit, Preventive exam or physical, Lab testing, X-rays, EKG, and any other Screening Service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the Physician or Clinic to know if my insurance will pay for my Medical Service or Visit, Preventive Exam or Physical, Lab Testing, X-Rays, EKG's, or any other Screening Service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility to know if my insurance has any Deductible, Co-payment, Co-insurance, Out-of-Network amount, Usual and Customary Limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to know if my PCP choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

Signature:_____ Date:_____

Responsible Party Name: _____

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Disclosures & Consents

Assignment of Insurance Benefits:
I hereby authorize direct payment of my insurance benefits to Durga Prasad Mekala MD or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Durga Prasad Mekala MD is unable to collect from my insurance carrier for whatever reason.

Medical/Medicaid/Champus Insurance Benefits:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Durga Prasad Mekala MD or the physician on by behalf.

Authorization To Release Non-Public Personal Information:
I certify that I have received and read a copy of the Durga Prasad Mekala MD Patient Information Policy. I hereby authorize Durga Prasad Mekala MD or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

Authorization To Mail, Call or Email:
I certify that I understand the privacy risks of the mail, phone calls, and email. I hereby authorize a Durga Prasad Mekala MD representative or my physician to mail, call, or email me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Durga Prasad Mekala MD to that effect in writing.

Lab/X-Ray/Diagnostic Services:
I understand that I may receive a separate bill if my medical care includes labs, x-ray's, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

Consent To Treatment:
I hereby consent to evaluation, testing, and treatment as directed by Durga Prasad Mekala MD, or Physician of his or her designee.

Patient Signature:_____ Date:_____

Guarantor Signature:_____ Date: _____
(if different from patient)
Guarantor Name (Print):_____

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Personal Medical History

Completed by (Please Sign):_____Date:_____

Family Doctor: _____ Phone:_____ Last Seen:_____
Specialty Doctor (Heart, Lung, Kidney etc.)_____

Advance Health Directive: (check what you have and please bring a copy to PCP)
Health Care Proxy Living Wills DNR
Do you wish to discuss these with a Health Care Provider? Yes No

List Surgeries and or Serious Injuries with approximate dates:_____
_____
_____
_____

List any problems you or any family member had with anesthesia (describe)_____
_____

Allergies and Reactions

To Medications:_____
To Food: _____
To Latex: _____ Seasonal/Environmental: _____Bee Stings:_____
To X-Ray Dye/Contrast: _____Iodine Products:_____
To Tape:_____Metals:_____
Other:_____

Medications you are currently taking:

List name, dose, how often. Include Prescription, Over the Counter, Inhalers, and Herbal Supplements or attach a list.(If you use an insulin pump, include your basal and bolus rates)

_____
_____
_____
_____
_____
_____

Pharmacy & Phone # where Prescriptions are filled:

_____

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Medical Conditons:

Mark "Yes" or "No". Please put when diagnosed or explain problem:

Yes No Arthritis (Osteo/Rheumatoid/Gout)_____
Yes No Breathing Problems(Asthma/COPD/Sleep Apnea)_____
Yes No Recent Upper Respiratory Infection (Pneumonia/Bronchitis)_____
Yes No Cancer_____
Yes No Circulation Problems (ex. Legs/Blood Clots/Neck Arteries)_____
Yes No Diabetes _____Do you test?_____ How Often?_____
Name of Mete r_____ Average Readings_____
High/Low_____
Yes No Heart Disease: Coronary Artery Disease/Angina_____
MI/ Heart Attack_____
Valve Problem _____
Irregular Heartbeat/Pacemaker/ICD _____
Angioplasty _____
High Cholesterol_____
Other_____
Yes No High Blood Pressure_____
Yes No Kidney (i.e. Stones, Decreased Function)_____
Yes No Bladder/Prostate (explain)_____
Yes No Liver (i.e. Cirrhosis, Hepatitis)_____
Yes No Neuromuscular (i.e. Seizures, tremors, Muscular Dystrophy)_____
Yes No Psychological (anxiety, depression, panic attacks)_____
Yes No Skin Problems (eczema, psoriasis, shingles, cancer)_____
Yes No Stroke/TIA _____
Yes No Stomach (i.e. Reflux, hiatal hernia)_____
Yes No Bowel (i.e. Crohns, polyps, IBS, Diverticuli)_____
Yes No Thyroid Disease_____
Yes No Trauma (i.e. Falls, Fractures, Major Accidents)_____
Yes No Steroid Therapy _____
Yes No Bleeding Problems_____
Yes No Other Medical Conditions:_____
_____
_____

DO YOU HAVE :

Mark "Yes" or "No'. Explain your problem.

Yes No Problems swallowing or eating?_____
Yes No Recent Gain or Loss of Weight ? (10lbs or more) _____
Yes No Loss of appetite or unable to eat longer than 3 days_____
Yes No Special Diet or Restrictions_____
Yes No Dentures (Circle all that apply) upper/lower, caps, crowns, braces, Loose teeth:

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Yes No Eye Problems (cataracts, glaucoma, macular degeneration)
glasses contacts intraocular lens prosthetic eye
Yes No Hearing problems (loss, ringing):_____
hearing aide right hearing aide left
Yes No Normal Bowel Habits: Frequency?_____
What I use to manage bowels: _____
Yes No Normal Urinary Habits._____
Frequency at night Incontinence Dropped Bladder

Yes No **FEMALE ONLY** Do you self Breast Exam ? _____
Last Menstrual Period_____
Yes No **MALE ONLY** Do you do self-testicular Exam ?_____
Yes No Do you smoke ?____How Much?_____ When Quit?_____
Yes No Do you drink alcohol ?_____How Much?_____ When Quit?_____
Yes No Do you use Recreational drugs?_____ How Much ?_____
When Quit?_____

Date of last exam:

_____ PAP
_____ TB
_____ Mammogram
_____ Prostate
_____ Eye
_____ Dental
_____ Hearing

Date of last Immunization:

_____FLU
_____Pneumovax
_____Tetanus
_____Hepatitis
_____Measles
_____Other -_____
_____Other- _____

PLEASE INDICATE WHICH INFECTIOUS DISEASES YOU HAVE HAD:

Yes No Measles Yes No Mumps Yes No Polio
Yes No Chicken Pox Yes No Scarlet Fever Yes No Shingles
Yes No VRE Yes No TB Yes No MRSA
Yes No C. Diff. Yes No Rheumatic Fever
Yes No Have you ever been in isolation in the hospital?_____
Why?_____When?_____
Yes No Do you have any pain?_____ Where? _____For how long?_____
Yes No Previous Blood Transfusions? _____
Yes No Any religious or other objection to blood products ?_____

Equipment you already have at your home: (Circle what you have) cane, wheelchair, walker, hospital bed, oxygen, braces, and prosthesis, CPAP/BIPAP device, blood pressure cuff, scale, glucose meter,_____
_____