REVISED 09-2015

Patient Information

NORTH DALLAS SURGICAL SPECIALISTS, P.A.

Please Print

Legal Name – Last: _____ First: _____ M.I. _____ Nickname _____

Address: _____ City: _____ State: _____ Zip Code: _____

Age: _____ Birthdate: ____/____/____ Sex: ❑ M ❑ F Social Security #: _____-_____-_____

Drivers License #:_____ Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widow(er)

Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino Preferred Language: _____

Race: ❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American
❑ White ❑ Native Hawaiian or Other Pacific Islander ❑ Some Other Race

Referring Doctor: First: _____ Last: _____ Phone: (___) _____

Primary Care Doctor: First: _____ Last: _____ Phone: (___) _____

Pharmacy Information

Pharmacy**:** _____ Location: _____ Phone #: _____

In addition to reviewing the medication list you provide, NDSS will request your medication history from your pharmacy.

Contact Information

❑ Check here if it is OK to leave a message on your answering machine (or voice mail)

List all phone numbers—in order of preference—where we may contact you:

	Location/Type (Home, Work, Cell, etc.)	Phone Number
1.	_____	(____) _____
2.	_____	(____) _____
3.	_____	(____) _____

List those we may speak with regarding your health information:

	Name	Relationship	Phone Number
1.	_____	_____	(___) _____
2.	_____	_____	(___) _____
3.	_____	_____	(___) _____

Email address: _____

Employer: _____ Employer address: _____

City: _____ State: _____ Zip Code: _____ Business Phone: (_____) _____

Insurance Information

Is your condition related to an on-the-job injury? (i.e., is this a worker's compensation claim?) ❑ Yes ❑ No

Primary Insurance

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Insurance Co: _____

Your relationship to policy holder: ❑ Self ❑ Spouse ❑ Child ❑ Other

Secondary Insurance

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Insurance Co: _____

Your relationship to policy holder: ❑ Self ❑ Spouse ❑ Child ❑ Other

HIPAA I acknowledge receipt of the privacy practices of North Dallas Surgical Specialists.

Responsible Party Statement and Payment of Benefits

As the responsible party, I understand that my health insurance policy is an arrangement between my insurance carrier and myself. This office will prepare any necessary reports and forms to assist me in making collection from the insurance company, however, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for all charges for services rendered. All charges not paid by my insurance company will be my responsibility. Fees for services are due at the time the services are rendered.

Notice of Physician Ownership

One or more of the physicians at North Dallas Surgical Specialists, P.A. have an ownership interest in the following facilities: Baylor Surgicare at Garland, Baylor Surgicare at North Dallas, and Rockwall Surgery Center. I understand that my physician may refer me to one of the facilities for services. I also understand that I may speak with my physician about his financial relationship with the facility and I may ask my physician to provide my treatment or surgery at a facility where he has no ownership interest.

Signature: **X** _____ Today's Date: _____/_____/_____