MEDICAL and SURGICAL CLINIC of IRVING

Alex W. Garcia, DPM

PATIENT INFORMATION

NAME:_____ TODAY'S DATE:_____

GENDER: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Widowed ☐ Divorced/Separated

Address_____ Apt. #:_____
City_____ State_____ Zip code_____
Home #:_____ Work #:_____ Cell #:_____
Date of birth:_____ Social Security #:_____ Age:_____
Shoe Size:_____ Shoe Width:_____

RESPONSIBLE PARTY INFORMATION

NAME:_____ Relation:_____
Home #:_____ Date of birth:_____ Social Security #:_____

INSURANCE INFORMATION

Is there a referral required from your PCP? ☐ Yes ☐ No Specialist Copay:_____

Primary Company:	Secondary Company:
Subscriber:	Subscriber:
Subscriber DOB:	Subscriber DOB:
Subscriber SS#:	Subscriber SS#:
Policy/ID #:	Policy/ID #:
Group #:	Group #:

EMERGENCY CONTACT INFORMATION

NAME:_____ Relationship:_____
Home #:_____ Cell #:_____ Other:_____

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PRIMARY CARE DOCTOR AND PHARMACY INFORMATION

Name of your Doctor:_____ Phone #:_____

When was your last visit to your PCP?_____

Pharmacy Name:_____ Phone #:_____

HOW DID YOU HEAR ABOUT US?

☐ Doctor ☐ Phone Book ☐ Insurance Co. ☐ Internet ☐ Other_____

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PERSONAL HEALTH HISTORY

Name:_____ Date:_____

Please Circle either Yes or No for ALL of the following question:

Cardiovascular

Y or **N** Anemia
Y or **N** Angina or chest pain
Y or **N** Bleeding problems
Y or **N** Blood or plasma transfusions
Y or **N** Blood pressure, high or low
Y or **N** Cramps in legs with walking
Y or **N** Heart trouble (pacemaker/valve replacement)
Y or **N** Mitral value prolapse
Y or **N** Shortness of breath with walking
Y or **N** Swelling in feet, ankles, or hands
Y or **N** Varicose veins or phlebitis
Y or **N** Stroke

Respiratory

Y or **N** Asthma
Y or **N** Bronchitis
Y or **N** Pneumonia
Y or **N** Shortness of Breath
Y or **N** Tuberculosis Dale

Musculoskeletal

Y or **N** Arthritis
Y or **N** Gout
Y or **N** Fibromyalgia

Social History

Y or **N** Use of alcohol
Y or **N** Use of tobacco
Y or **N** Use of drugs
Y or **N** Aids or HIV

Gastro Intestinal

Y or **N** Reflux
Y or **N** Ulcers
Y or **N** Spastic Colon
Y or **N** Chron's Disease
Y or **N** Hepatitis

Genito Urinary

Y or **N** Kidney disease
Y or **N** Venereal Disease
Y or **N** Burning on urination or frequently voiding

Dermatological

Y or **N** Allergies
Y or **N** Eczema
Y or **N** Psoriasis

Other

Y or **N** Thyroid
Y or **N** Pregnant
Y or **N** Diabetic
Y or **N** Cancer

Please list any other condition/s:

_____

_____

_____

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PERSONAL HEALTH HISTORY

Please list all pertinent matters. If none apply, please write NONE in the correct place

Previous Hospitalizations, surgeries, serious illness. List in chronological order (dates)
Medications (List all including non-perscriptions):
Allergies to foods, medications, materials. List ALL:

Family History **Disease** **If deceased - cause and age**

Father_____

Mother_____

Reviewed by:_____D.P.M. Patient Signature:_____

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REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I, _____, herby authorize Dr. Alex Garcia and his staff to disclose information to the following person(s) about my procedures, as well as any other information concerning my health. I also authorize the following person(s) to receive information concerning my financial statement.

Name	Phone	Relationship	Date	Initials
1_____	_____	_____	_____	_____
2_____	_____	_____	_____	_____
3_____	_____	_____	_____	_____
4_____	_____	_____	_____	_____
5_____	_____	_____	_____	_____
6_____	_____	_____	_____	_____

Note:

There will be times that this office will call and leave messages regarding appointments, prescriptions, medical equipment and orthotics, or materials regarding my financial status.

I understand that I have the right to revoke this authorization at any time by written notification.

_____ _____

Signature **Date**

MEDICAL and SURGICAL CLINIC of IRVING

ALLERGY IMMUNOLOGY & RHEUMATOLOGY
RENUKA V. BASAVARAJU, M.D.

CARDIOLOGY
J. DOUGLAS OVERBECK, M.D.

ENDOCRINOLOGY
RAJIV DATTATREYA, M.D.

FAMILY PRACTICE
ALLAN J. FURMAN, M.D.
JACK E. IRELAND, M.D.
JEFFREY C. MASON, M.D.
JENNY M. OLIVO, M.D.
DENNIS PANGTAY, M.D.
HIEN "HENRY" Q. PHAM, M.D.
CHRISTOPHER SHELTON, M.D.
DARRYL B. TISHERMAN, M.D.
CRISTINA VALDEZ, M.D.
STEFANIE LEE, P.A.

GASTROENTEROLOGY
JEFFREY S. FINE, M.D.
MABEL ZEVALLOS, M.D.

INTERNAL MEDICINE
STEVEN A. BELL, M.D.
SHARON R. CEBIK, M.D.
TY C. MADDOX, D.O.
GABRIEL ZEVALLOS, M.D.

OBSTETRICS & GYNECOLOGY
PATRICIA MARROQUIN, M.D.
JOHN A. MAXEY, M.D.

OPTHALMOLOGY
TIMOTHY THOMASON, M.D.
MICA INGRAM, AU D.

PEDIATRICS
SUSAN H. HELLER, M.D.
KAREN D. HOLLAND, M.D.
JOAN P. KAY, M.D.
DARLENE A. KURIAN, M.D.
NATALYA SHANNON, M.D.
TAMMI WILLIAMS, M.D.
THOMAS ATKINS, R.N., P.N.P.
DEBBIE BALTHROP, R.N., P.N.P.

RADIOLOGY
HELEN T. RAMEY, M.D.
SUSAN STRATEN, D.O.

SURGERY
R. BERNARD ROCHON, M.D.

ADMINISTRATION
EXECUTIVE DIRECTOR
JEFFRY M. DUKE, CPA
CHIEF OPERATING OFFICER
LYNETT HOLLYFIELD

Medical and Surgical Clinic of Irving, P.A.
Financial Policy

We appreciate your trust in us and the opportunity to serve you. As a part of our practice, we try to offer efficient and helpful billing services. To this end, we ask you to read the following statement of our financial billing policy. Please sign it prior to your exam or treatment.

Participating Plans
Please bear in mind that it is your responsibility to pay as a deposit and deductible amount, co-insurance, co-pay or any other balance not covered by your insurance company prior to receiving services. Even though we assist you in receiving reimbursement from your insurance company, please understand that you, the patient, ultimately have the final responsibility of your bill. Additionally, we cannot waive co-pays for our patients since this is an insurance plan requirement.

Self Pay
All self-pay patients are required to pay in full on the day of their scheduled exam or procedure.

Cancellation of Scheduled Procedures
Our office requires 24 hours notice when canceling a procedure/surgery. There is a $20 charge for missed appointments. Any appointment rescheduled with less than 4 hours notice is subject to the $20 fee.

Payments
Bills will be issued after the insurance company pays its portion of the bill. Balances are due in full 30 days of when the bill is issued to you. We do not have the ability to carry patient balances over any extended period. We accept cash, checks, and credit cards as forms of payment. We also offer Care Credit, a patient payment plan, which is subject to credit approval.

Our practice is committed to providing the best care for our patients. Our charges are within the usual and customary range for this area.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read, understood, and agreed to this Financial Policy.

_____ _____
Signature **Date**

2021 North MacArthur Boulevard, Suite 150, Irving, Texas 75061
(972) 253-4200
www.mscitx.com

Medical and Surgical Clinic of Irving, P.A.
2021 North MacArthur Blvd. Suite 150, Irving, Texas 75061
972-253-4200

Acknowledgement of Receipt of Notice of Privacy Policy

Today's Date:_____

Patient Name:_____ Date of Birth:_____

Patient Social Security #:_____

Your name if not the patient:_____

Your date of birth:_____

To avoid asking you to sign this form again at future appointments, please list all MINOR dependants that are patients at this clinic that you are legally responsible for so that we may indicate in the computer screen the receipt of this document. Please do not include your spouse. All adults will be required to sign this acknowledgement individually.

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

I hereby acknowledge that I have been given a copy of the "Notice of Privacy Policy" for the Medical and Surgical Clinic of Irving, P.A. Please notate in my family's profiles of this acknowledgement.

_____ _____

Patient/Legal Guardian Signature **Date**