PATIENT REGISTRATION

Patient Information

Today's Date_____ **Birthdate**_____**Age**_____

Name_____Social Security#_____
Last Name First Name M.Initial
How do you wish to be addressed? _____
Address_____Home Phone_____
City_____State_____Zip Code_____
Sex ☐M ☐F ☐Single ☐Married ☐Widowed ☐Divorced
Business Phone_____Alternate Phone_____
Patient Employed by_____Occupation_____
Business Address_____City_____State___Zip_____
☐Full Time ☐Part Time ☐Retired ☐Not Employed ☐Student
Spouse's Name_____D.O.B._____
Social Security#_____Employer_____
In Case of Emergency_____Phone_____

Primary Insurance

Subscriber Name_____Relation_____D.O.B._____
Insurance Company_____Plan Type_____
ID#_____Group#_____

Additional Insurance

Subscriber Name_____Relation_____D.O.B._____
Insurance Company_____Plan Type_____
ID#_____Group#_____

Assignment and Release

I, the undersigned, certify that I or my dependent) have insurance coverage with _____ (Name of Insurance Company) and assign Dr. Thomas K. Alexander or Dr. Trung N. Dao all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

Health History

Patient Name _____ Today's Date _____
Age _____ Birthdate _____ Date of last physical _____
Reason for visit _____

Symptoms

Check symptoms you have or have had in the past.

General
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

Muscle/Joint/Bone
Pain,weakness,numbness in:
- ☐ Arms ☐ Hands
- ☐ Back ☐ Hips
- ☐ Feet ☐ Legs
- ☐ Shoulders ☐ Neck

Genito-urinary
- ☐ Blood in urine
- ☐ Lack of bladder control
- ☐ Painful urination

Gastrointestianl
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

Eye,Ear,Nose,Throat
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear Discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision—Flashes
- ☐ Vision—Halos

Skin
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore won't heal

Men only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

Women only
- ☐ Abnormal pap
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last period _____
Date of last pap _____
Have you had a mammogram? ☐Y ☐N
# of children _____

Conditions

Check conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problem
- ☐ Psychiatric care
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid problem
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal disease

Thomas K. Alexander, M.D.
Trung N. Dao, M.D.
399 W. Campbell Rd. #212
Richardson, Texas 75080

Acknowledgement Form

I,_____, acknowledge and have been made aware of this Notice of Privacy Rights in which I may review. I give my permission to Dr. Thomas K. Alexander or Dr. Trung N. Dao to use and disclose my health information in accordance with it.

Consent for Treatment

I,_____, acknowledge the need for medical care and hereby request and voluntarily consent to receive the usual medical services as well as the diagnostic procedures and medical treatment. **I understand that there is no guarantee as to the outcome or results of the treatments or examinations received.**

Confidentiality

I acknowledge that any and all medical care that I receive at this clinic will be treated with the utmost confidentiality. However, to facilitate my medical care, I hereby authorize Dr. Thomas K. Alexander or Dr. Trung Dao to provide information about my treatment and medical condition to the following individuals:

Name	Relationship	Name	Relationship
Name	Relationship	Name	Relationship

Patient Signature _____ Date _____

Witness Signature _____ Relationship _____

Request for Medical Records

Date:_____

Patient Name:_____

Date of Birth:_____

I hereby request that my medical records be released from:

Doctor or facility name:_____

Address:_____

Phone:_____

Fax:_____

Please Forward These Records To:

Thomas K. Alexander, M.D.
Trung N. Dao, M.D.
399 W. Campbell Rd. #212
Richardson, Texas 75080
Phone: 972-234-4994
Fax: 972-234-4412

_____

Patient Signature

Photocopied signatures are valid as originals