2217 Park Bend Dr., Ste 220
Austin, TX 78758
Phone: 512-491-6542 | Fax: 512-491-0161

Patient Registration Form

Today's date:				PCP:
PATIENT INFORMATION				
Patient's last name:	First:	Middle:		Marital status (circle one) Single / Mar / Div / Sep / Wid
Email Address:		Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Social Security no.:		Home phone no.:
City:	State:	ZIP Code:		Cell phone no.:
Occupation:	Employer:			Employer phone no.:
Preferred Language: ❑ English ❑ Spanish ❑ Other:				
Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino				
Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White				
Gender Identity: ❑ Male ❑ Female ❑ Transgender Male ❑ Transgender Female ❑ Genderqueer ❑ Other ______________ ❑ Decline to Answer				
Sexuality: ❑ Heterosexual ❑ Homosexual ❑ Bisexual ❑ Something else : _________ ❑ Don't Know ❑ Decline				

INSURANCE INFORMATION				
(Please give your insurance card to the receptionist.)				
Name of primary insurance:				
Policy holders name:	Policy holders S.S. #:	Birth date: / /	Group #:	Policy #:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other
Employer:	Employer address:		Employer phone #: ( )	
Name of secondary insurance (if applicable):	Subscriber's name:		Group #:	Policy #:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

I, the undersigned authorize payment of medical benefits to ***Northstar Surgery Specialists, P.A.*** for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided by me. This information will be used for the purpose of evaluating and administering claims of benefits.

______________________________ ______________

Patient/Guardian signature **Date**

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Additional Information

1. **In case of an emergency**, please notify:

   Name: ___________________________________ Phone Number: ________________________________

   Relationship to patient: ____

   May we inform this person of confidential information? YES NO

   Name: ___________________________________ Phone Number: ________________________________

   Relationship to patient: ____

   May we inform this person of confidential information? YES NO

2. Can confidential messages be left on your:

   Home telephone answering machine: ☐ Yes ☐ No
   Cell phone voicemail: ☐ Yes ☐ No
   Work voicemail: ☐ Yes ☐ No
   Personal Email ☐ Yes ☐ No

3. Do you have a LIVING WILL? ☐ Yes ☐ No

4. Do you have a Medical POWER OF ATTORNEY? ☐ Yes ☐ No

   If yes, Name __________________________________ Number __________________________________

5. Pharmacy Information:

   Preferred Pharmacy: ______________________ Pharmacy Phone #: _____________________

   Pharmacy Address: ____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES & CANCELLATION POLICY

I have reviewed the Notice of Privacy Practices of NorthStar Surgery Specialists, P.A., which explains in plain language how my protected health information (PHI) will be used and disclosed, my individual rights, and the practice's legal duties with respect to my PHI. I understand that I am entitled to receive a copy of this information upon request.

I also acknowledge the following cancellation/no show policy: **New patients** that no show to a scheduled appointment are subject to a **$50** no show charge. **Established/post-operative** patients are subject to a cancellation/reschedule/no show charge of **$50** if a 24 hour notice is not given, **7 day notice must be given to cancel/reschedule surgery, if 7 day notice is not given, you are subject to a $250 cancellation fee.**

Signature ____ Date __________________________________

Release of Medical Records

I am requesting that the medical information be transferred to **Vineet Choudhry MD.**

I understand that the information in my or my child's health record may include information relating to STD, AIDS, or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Signature ____ Date _________________________________

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Medical History Form

Date of Birth: ____ / ____ / ______ Sex ☐ M ☐ F Height: ________ Weight: ________

Primary Care Physician: ____________________ Referring Physician: ______________________

Address ____________________ Address ______________________

City/State/Zip ____________________ City/State/Zip ______________________

Chief Complaint / Purpose of Visit:

____

Medical History - Please list all Current and Past Medical Conditions: ☐ None

				Other:
☐	Heart Disease	☐	COPD/Emphysema/Bronchitis	
☐	Previous Heart Attack / Chest Pain	☐	Asthma	
☐	Congestive Heart Failure	☐	Other Lung Disease	________________
☐	Heart Valve Disorders		Type: ________________	
☐	Heart Rhythm Problems	☐	Cancer	________________
☐	High Blood Pressure		Type: ________________	
☐	High Cholesterol / Lipids	☐	Gall Bladder Disease	________________
☐	History of Stroke		Type: ________________	
☐	Diabetes	☐	Bowel Disease	________________
☐	Peripheral (Leg) Vascular Disease		Type: ________________	
☐	Epilepsy / History of Seizures	☐	Hepatitis / Liver Disease	________________
☐	Arthritis		Type: ________________	
☐	Anemia	☐	Kidney / Bladder Disease	________________
☐	Stomach Ulcer		Type: ________________	
☐	Clotting / Bleeding Disorder	☐	Thyroid Disease	________________
	Type: ____________________		Type: ________________	

Please list any pertinent descriptions, if needed, of any above conditions checked:

____

____

Surgical History - Please list Previous Operations and the year when they were performed: ☐ None

	Procedure	**Year**		**Procedure**	**Year**		**Procedure**	**Year**
☐	Gallbladder (Cholecystectomy)	_____	☐	Coronary Artery Bypass	_____	☐	Thyroid	_____
☐	Appendix (Appendectomy)	_____	☐	Other Heart Surgery	_____	☐	Breast Biopsy/Mastectomy	_____
☐	Hernia Repair (any)	_____	☐	Lung Surgery	_____	☐	Tonsillectomy	_____
☐	Stomach/Bowel Surgery	_____	☐	Joint/Back Surgery	_____	☐	Plastic Surgery	_____
☐	Rectal/Hemorrhoid	_____	☐	Hysterectomy/C-Section	_____	☐	Skin surgery (Mole Removal, Graft, etc.)	_____

☐ Other ____

Medications - Please list all medications you are taking, including over-the-counter and herbal: ☐ None

____

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Allergies – Please list any allergies to medications below: ☐ None ☐ Latex

____

____

Social History:

Marital Status:
☐ Single
☐ Married
☐ Divorced
☐ Widowed

Do you have children?
☐ Yes
☐ No
How many? _________
Ages _______________

Do you smoke or chew tobacco?
☐ Never Packs per day: _______
☐ Chew Number of years: _______
☐ Smoke Have you tried to quit? ☐ Yes ☐ No
☐ Former Smoker → Date Quit _______________

Do you use illicit drugs? ☐ Yes ☐ No
Type and Frequency __________________
____

Do you drink alcohol? ☐ Yes ☐ No
Type and Frequency ____
____

Occupation ____

Family History: Does anyone in your family have any of the following? If so, list your relation to them:

☐	Breast Cancer	________________	☐	Stroke	________________
☐	Colon Cancer	________________	☐	Epilepsy / Seizures	________________
☐	Ovarian/Uterine Cancer	________________	☐	GallBladder Disease	________________
☐	Melanoma	________________	☐	Bleeding / Clotting History	________________
☐	Prostate Cancer	________________	☐	Diabetes	________________
☐	Lung Cancer	________________	☐	Heart Disease	________________
☐	Pancreatic Cancer	________________	☐	Lung Disease	________________
☐	Lymphoma / Leukemia	________________	☐	High Blood Pressure	________________
☐	Thyroid Cancer	________________	☐	High Lipids / Cholesterol	________________
☐	Skin Cancer	________________	☐	Hemorrhoids	________________
☐	Other Cancer (Type and Family Member)	________________	☐	Other _______________	________________

Will you absolutely refuse blood transfusions under any circumstances? ☐ Yes ☐ No

X-Rays / Labwork done: ☐ None
☐ Yes – Type and Location: ____
____

Are your immunizations up to date? ☐ Yes ☐ No

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Are you currently being treated by a physician for any of the following? Please check the box if "Yes."

Please explain any "Yes" answers at the bottom of this page.

General
- ☐ Weight Loss ________lbs
- ☐ Weight Gain ________lbs
- ☐ Fever/Chills

Eyes
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Recent vision changes

Cardiovascular
- ☐ Chest pain
- ☐ Irregular Heartbeat
- ☐ Shortness of breath
- ☐ Feet / leg swelling
- ☐ Varicose veins

Women Only:

Last pap smear _______
- ☐ Number of pregnancies _______
- ☐ Number of deliveries _______
- ☐ Venereal disease
- ☐ Menstrual irregularities
- ☐ Menopause, age? _______
- ☐ Vaginal discharge

Men Only:

Last Prostate Exam (YR) _________

Last PSA Test (YR) _________
- ☐ Prostate disease
- ☐ Testicular lumps, pain
- ☐ Venereal disease

Gastrointestinal

Last Colonoscopy (year) _________

Last Flex. Sig. (year) _________

Last stool occult blood test ________
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Constipation

Urinary
- ☐ Painful urination
- ☐ Slow/frequent urination
- ☐ Infections
- ☐ Blood in urine
- ☐ Kidney stones

Breast

Last mammogram (date) _______
- ☐ Monthly self exams
- ☐ Lumps
- ☐ Nipple discharge
- ☐ Pains

Hematologic/Lymphatic
- ☐ Easy bleeding or bruising
- ☐ Anemia

Blood transfusion (year) _______

Musculoskeletal
- ☐ Fractures/dislocations
- ☐ Muscle pain/cramps

Neurologic
- ☐ Headaches
- ☐ Weakness
- ☐ Dizziness
- ☐ Numbness / tingling

Psychiatric
- ☐ Depression
- ☐ Trouble sleeping
- ☐ Schizophrenia
- ☐ Alcohol dependency
- ☐ Drug dependency

Respiratory
- ☐ Cough
- ☐ Trouble breathing
- ☐ Wheezing
- ☐ Pneumonia

Ears/Nose/Mouth/Throat
- ☐ Hearing loss
- ☐ Nose bleeds
- ☐ Gum problems
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Trouble swallowing

Immunologic
- ☐ HIV / AIDS
- ☐ Hepatitis (A, B, or C?)

Skin
- ☐ Rashes / dermatitis
- ☐ Changes in moles

Please explain any "Yes" answers below:

____

____

____

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Credit Card on File Policy

Please complete this form in its entirety. This form serves as confirmation that you are aware that Northstar Surgery Specialists P.A. has a policy that requires each patient to follow a payment plan with a credit card on file.

I,_________________hereby consent to follow the payment agreement given below with strict abidance. Should I have any difficulty, I fully accept it as my responsibility to report this matter to Northstar Surgery Specialists before my next payment, so as to allow for alternate arrangements to be made.

This policy is in effect due to the raise in patient deductibles and patient responsibility due to the change in health insurance policies and guidelines. If you have any questions about your coverage, please contact your insurance company on the number listed on the back of your insurance card.

If surgery is required, a cost estimation will be provided to you prior to surgery **upon request**.

The benefit of this form is that no cost will be collected up front prior to surgery. By signing below, this allows us to set you up on a payment plan of $100/month for any and all charges incurred from office visits and operations. If you decline to put your card on file, you will be responsible for paying your amount due in full PRIOR TO SERVICES, unless alternate payment arrangements have been agreed upon by the billing administrator of NorthStar Surgery Specialists,P.A.

Patient Name (Please Print):____
Date of Birth: ____________ Email for notification: ____

YOU WILL RECEIVE A CONFIRMATION EMAIL PRIOR TO ANYTHING BEING CHARGED ON YOUR CREDIT CARD

The below credit card will be used for any charge incurred from office visits/operations. This card will be set up for a payment plan of $100/month after insurance's final determination unless otherwise specified (defaults to the 1st day of every month unless otherwise specified).

Please use Credit Card #:____ EXP:_____________

CVV: ___________ Billing Zip Code: ___________ on the ________ day of every month.

Signature: ____ **Date:** ____________________

OR

I decline to put my card on file, with the understanding that will be responsible for payment in FULL of any balance prior to any procedure performed/office visit.
Signature: ____**Date:**_________________________

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Statement of Billing Practices

I acknowledge that I have had an opportunity to read and understand the billing practices outlined below.
I have had the opportunity to ask any questions I may have.
If I have questions, I understand that it is the patient's responsibility to obtain answers to their questions.

Signature Date

Patient will receive a total of 3 bills via mail to the address given on the patient registration form. If no payment is received, patient is subject to consideration for our external collection agency.

If an email is on file, we will attempt to send you a courtesy email when your account is at risk of being referred to our collection agency. We ask that upon receipt, you reach out to our office within 5 business days to arrange payment.

As a final attempt, we will attempt to reach out to you via phone once to the phone number listed on file, this FINAL attempt will be made 5 business days prior to your account being referred to collections.

We ask that payment be remitted to our office within 30 days of receipt of statement.

We offer courtesy flexible payment plans for balances due to help patients with the amounts due.

We also offer online payments for your convenience on our website:
WWW.NORTHSTARSURGERY.COM

Feel free to give us a call in order to discuss your options at:
512-697-7082