APEX SURGICAL CARE, P.A.

Name: _____

Date: _____

Social History

Recent Travel	◯ Yes	◯ No
Alcohol	◯ Yes	◯ No
Recreational drugs	◯ Yes	◯ No
Marital status	◯ Yes	◯ No
Smoking	◯ Yes	◯ No

Family History of Cancer

Mother	◯ Yes	◯ No
Father	◯ Yes	◯ No
Siblings	◯ Yes	◯ No

Past Medical History

Stroke	◯ Yes	◯ No
High blood pressure	◯ Yes	◯ No
Heart disease	◯ Yes	◯ No
Heart Failure	◯ Yes	◯ No
Diabetes	◯ Yes	◯ No
Hyperthyroidism	◯ Yes	◯ No
DVT	◯ Yes	◯ No
Pulmonary embolism	◯ Yes	◯ No
COPD	◯ Yes	◯ No
Cough	◯ Yes	◯ No
Keloids	◯ Yes	◯ No
Abdominal pain	◯ Yes	◯ No
Chronic diarrhea	◯ Yes	◯ No
Hepatitis C	◯ Yes	◯ No
Hepatitis B	◯ Yes	◯ No
HIV positive	◯ Yes	◯ No
Renal failure	◯ Yes	◯ No
Cancer, breast	◯ Yes	◯ No
Radiation therapy	◯ Yes	◯ No
Chemotherapy	◯ Yes	◯ No
Blood transfusion	◯ Yes	◯ No
Hemophilia A	◯ Yes	◯ No
Breast lump	◯ Yes	◯ No

Surgical History

No previous Surgery	◯ Yes	◯ No
Hysterectomy	◯ Yes	◯ No
Inguinal hernia repair	◯ Yes	◯ No
Ventral hernia repair	◯ Yes	◯ No
Cholecystectomy	◯ Yes	◯ No
Umbilical hernia repair	◯ Yes	◯ No
Appendectomy	◯ Yes	◯ No
C section	◯ Yes	◯ No
Neck mass	◯ Yes	◯ No
Heart catheterization	◯ Yes	◯ No
Repair of fractures	◯ Yes	◯ No
Spinal surgery	◯ Yes	◯ No
Gastric bypass	◯ Yes	◯ No
Gastric stapling	◯ Yes	◯ No
Gastrostomy	◯ Yes	◯ No
Thyroidectomy	◯ Yes	◯ No
AAA repair	◯ Yes	◯ No
Breast biopsy	◯ Yes	◯ No
Breast reduction	◯ Yes	◯ No
Breast augmentation	◯ Yes	◯ No
Colon ressection	◯ Yes	◯ No
Removal of spleen	◯ Yes	◯ No

Constitutional

Recent weight change	◯ Yes	◯ No
Loss of appetite	◯ Yes	◯ No
Recent fever	◯ Yes	◯ No
Weakness	◯ Yes	◯ No
Fatigue	◯ Yes	◯ No
Night sweats	◯ Yes	◯ No

Psychology

Depression	◯ Yes	◯ No
Anxiety	◯ Yes	◯ No
Eating disorder	◯ Yes	◯ No

Genitourinary male (only fill if male)

Hard testicle	◯ Yes	◯ No
Groin hernia	◯ Yes	◯ No
Difficulty urinating	◯ Yes	◯ No

Genitourinary female (only fill if female)

Pelvic pain	◯ Yes	◯ No

ENT/Respiratory

Recent cough	◯ Yes	◯ No
Recent cold	◯ Yes	◯ No

Cardiology

Shortness of breath	◯ Yes	◯ No
Murmurs	◯ Yes	◯ No
Palpitations	◯ Yes	◯ No
Chest pain	◯ Yes	◯ No
Swelling of the legs	◯ Yes	◯ No

Dermatology

Rash	◯ Yes	◯ No
Moles	◯ Yes	◯ No
Lumps	◯ Yes	◯ No
Previous skin cancer	◯ Yes	◯ No

Endocrinology

Cold intolerance	◯ Yes	◯ No
Heat intolerance	◯ Yes	◯ No

Hematology

Easy bleeding	◯ Yes	◯ No
Swollen glands	◯ Yes	◯ No
Varicose veins	◯ Yes	◯ No
Easy bruising	◯ Yes	◯ No

Gastroenterology

Blood in stool	◯ Yes	◯ No
Diarrhea	◯ Yes	◯ No
Vomiting	◯ Yes	◯ No
Constipation	◯ Yes	◯ No
Nausea	◯ Yes	◯ No
Difficulty swallowing	◯ Yes	◯ No
Abdominal pain	◯ Yes	◯ No
Change in bowel habits	◯ Yes	◯ No
Frequent heartburn	◯ Yes	◯ No

Apex Surgical Care, P.A. • Ricardo Lebron Valdez, MD

929 N. Galloway Ave. • Suite 301 • Mesquite, Texas 75149

PATIENT INFORMATION

Assignment of Benefits/Release of Information/Notice of Privacy Practices/Appointment of Authorized Representative

****Please read and initial each paragraph****

_____ **Apex Surgical Care, P.A.**, and associated physicians are committed to securing the privacy of your health information. We are supplying you with a copy of our Notice of Privacy Practices. You are not required to read this notice. By initialing, you are acknowledging receipt of this notice.

_____ I request that payment of authorized Medicare and other insurance benefits be made on my behalf to **Apex Surgical Care, P.A.** for any services furnished to be by any healthcare providers associated with that group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or insurance company any information needed to determine these benefits or the benefits payable for related services.

_____ I appoint **Apex Surgical Care, P.A.** to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

_____ Unless I request to the contrary, in writing, I will recieve appointment reminders on my home telephone answering system and/or appointment reminder cards sent by mail, whichever is the policy of the practice.

Patient Financial Responsibility Statement

In order to maintain our fees at the lowest possible level, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward that end. We encourage you to discuss it with us and to ask questions.

We understand that your health coverage is provided through _____
(Insurance Company)

- If you have out-of-network benefits, we will happily file claims on your behalf.
- You must pay any co-payment and applicable deductible amounts at the time of service unless other arrangements have been made with our office.
- The remainder of your bill will be sent to your health plan for direct payment to our office.
- If your insurance carrier has not paid our claim within 45 days, we will expect payment from you.
- If, by mistake, your health plan remits payment to you, please send it to us along with all paperwork sent to you at the time.
- You will remain responsible for amounts and any services that are not covered by your insurance plan.
- Your health plan may refuse payment of a claim for some of the following reasons:
    1) This is a pre-existing illness that is not covered by your plan
    2) You have not met your full calendar year deductible
    3) The type of medical service required is not covered by your plan
    4) The health plan was not in effect at the time of service
    5) You have other insurance which must be filed first

Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as the patient to pay the denied amounts in full.

Our primary mission is to provide you with quality, cost effective, medical care. Together we are trying to adapt to the changing way that health care is financed and delivered. Again, we value you as a patient and our first priority is to provide you with the best possible care. With this housekeeping chore complete, we are pleased to serve you.

Sincerely,
Apex Surgical Care, P.A.

_____**Please note if you cancel surgery or do not show , you will be charged 100.00 dollars which will be your sole responsibility and are not refundable.**

I have completed this form with accurate information. I have read and understand my obligations and responsibilities. I acknowledge that I am fully responsible for supplying correct insurance information, billing information, and payment of any services not covered or approved by my insurance carrier.

_____ _____
Signature of Patient or Authorized Representative Date

APEX SURGICAL CARE, P.A.

Ricardo Lebron Valdez, M.D
929 N. Galloway Ave. Suite 301 Mesquite, TX 75149

Consent to Release Personal Health Information

Patient: _____

Date of Birth: _____ Date: _____

List all family members or friends you give the staff at Apex Surgical Care, P.A. your authorization to release your personal health information to:

_____ _____
FULL NAME RELATIONSHIP TO PATIENT

_____ _____
FULL NAME RELATIONSHIP TO PATIENT

_____ _____
FULL NAME RELATIONSHIP TO PATIENT

_____ _____
FULL NAME RELATIONSHIP TO PATIENT

Do you authorize staff members of Apex Surgical Care, P.A. to leave messages on your voicemail or answering machine regarding results or appointments?

Circle one: YES NO

Do you authorize staff members of Apex Surgical Care, P.A. to e-mail your personal information to the e-mail address you provide?

Circle one: YES NO

If yes, please provide address: _____@_____

This authorization shall expire upon this expiration date: _____
** This Authorization will not expire unless I list a date of expiration or written notification is received.

☐ I understand I have the right to revoke this authorization at any time. I understand I must do so in writing and present the written revocation to Apex Surgical Care, P.A. staff member.

☐ I understand the revocation will not apply to information that has already been released.

☐ The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____
Signature of Patient/Legal Representative Date

If signed by legal representative, relationship to patient: _____

Apex Surgical Care, P.A. • Ricardo Lebron Valdez, MD

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PATIENT INFORMATION

Patient Registration Information

Name: (First) _____ (MI) _____ (Last) _____

Home Phone: (____) _____ Work: (____) _____

Cell: (____) _____ Email: _____

Address: _____
Street Apt. City State Zip

DOB: ____/____/____ Age: _____ Sex: _____ Social Security #: _____

Driver's License #: _____ Reason for Visit: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referred by: _____ Primary Physician: _____
Name of Physician/Individual

Are you employed? ___ Yes ___ No ___ Full-Time ___ Part-Time ___ Self-Employed ___ Retired
Are you a student? ___ Yes ___ No ___ Full-Time ___ Part-Time
Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed
Is the patient: ___a minor child* ___ an adult dependent*
*If you checked either, please see the receptionist for additional information.

Primary Insurance Information

Please present your card at each visit. Deductible amount: _____ Co-pay amount: _____ PCP: _____

_____
Insurance Company Name Claims Mailing Address City State Zip

_____
Telephone Contact Person Group # Policy #

_____
Primary Insured Insured's DOB Insured's SS # Relationship to Patient

Employer: _____

Secondary Insurance Information

Please present your card at each visit. Deductible amount: _____ Co-pay amount: _____ PCP: _____

_____
Insurance Company Name Claims Mailing Address City State Zip

_____
Telephone Contact Person Group # Policy #

_____
Primary Insured Insured's DOB Insured's SS # Relationship to Patient

Employer: _____

Accident Information

Is this illness/injury the result of an accident? ___ Yes ___ No
Where did it occur? ___ Work ___ Auto ___ Other Date of accident _____
Have you reported the illness/injury to your employer? ___ Yes ___ No

Patient Initials _____