Henry E. Martinez M.D.

General, Vascular & Laparoscopic Surgery

REGISTRATION FORM

Date: _____ Home Phone: _____

Name: _____ _____ _____ Cell Phone: _____

Last Name First Name MI Work Phone: _____

Address: _____ Social Security: _____

City: _____ State: _____ Zip Code: _____

Sex: ☐ M ☐ F Age _____ Date of Birth _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor ☐ Other

Patient Employer/School: _____ Occupation: _____

Employer Address: _____ State: _____ Zip: _____

Spouse Name: _____ Employer: _____ Spouse Work Phone: _____

Contact in case of Emergency: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Whom my we thank for referring you? _____

PLEASE COMPLETE THIS SECTION IF PATIENT IS A MINOR OR DEPENDENT

Parent/Guardian Name: _____ _____ _____ Home Phone: _____

Last Name First Name MI Work Phone: _____

Address: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security: _____

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT _____ _____ _____

Last Name First Name MI

Relation to Patient: _____ Birthdate: _____ Social Security # _____

Address (If different from patient) _____

City: _____ State: _____ Zip: _____ Phone: _____

PERSON RESPONSIBLE EMPLOYED BY _____ OCCUPATION _____

Business Address: _____

City: _____ State: _____ Zip: _____ Business Phone: _____

INSURANCE COMPANY NAME _____ ID/POLICY # _____

GROUP/CODE _____ DATE EFFECTIVE _____

ADDITIONAL INSURANCE

IS PATIENT COVERED BY ADDITIONAL INSURANCE ☐ Yes ☐ No

POLICY HOLDER NAME _____ _____ _____

Last Name First Name MI

Relation to Patient: _____ Birthdate: _____ Social Security # _____

Address (If different from patient) _____

City: _____ State: _____ Zip: _____ Phone: _____

PERSON RESPONSIBLE EMPLOYED BY _____ OCCUPATION _____

Business Address: _____

City: _____ State: _____ Zip: _____ Business Phone: _____

INSURANCE COMPANY NAME _____ ID/POLICY # _____

GROUP/CODE _____ DATE EFFECTIVE _____

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MEDICAL HISTORY FORM

Date: _____

Last Name: _____ First Name: _____ MI _____
Date of Birth _____
Reason for visit/symptoms: _____
_____
_____

PLEASE LIST ANY SERIOUS / CHRONIC CONDITIONS ☐ Diabetes ☐ Heart Disease ☐ Cancer
☐ High Blood Pressure ☐ Rectal Bleeding ☐ Abdominal Pain ☐ Breast Lump ☐ Thyroid Problems
☐ Stroke ☐ Others (please specify) _____
_____

PAST SURGERIES AND DATES

SURGERIES	DATE

MEDICATIONS

List the medications you are currently taking including over the counter

Medication (Name)	Dosage (How Much?)	Frequency (How often?)	Route (How to take it?)

ALLERGIES

List allergies to medications and explain reaction

Medication (Name)	Reaction

FAMILY MEDICAL HISTORY

	Cancer (What Kind?)	Heart Disease	High Blood Pressure	Diabetes	Other
FATHER					
MOTHER					
BROTHERS					
SISTERS					
CHILDREN					

DO YOU SMOKE ☐ YES ☐ NO QUANTITY _____ DO YOU DRINK ☐ YES ☐ NO QUANTITY _____
Where you referred to our office: ☐ YES ☐ NO If Yes, by whom? _____
PRIMARY CARE PHYSICIAN (PCP) _____
Preferred Pharmacy: _____ _____ _____
Name Location Phone Number

PATIENT AUTHORIZATION

I hereby authorize Henry Martinez, MD, PA, to apply for benefits on my behalf for covered services rendered. I certify that the information I reported with regard to my insurance coverage is correct. I also authorize the release of any necessary information, including medical information if requested by the above names insurance company. I permit a copy of this authorization to be used in such instance.

By signing below, I agree to pay all charges for services rendered by Henry Martinez, MD, PA which is not covered by the above referenced insurance coverage. If it becomes necessary for Henry Martinez, MD, PA to seek judicial action to enforce the above agreement, I agree to pay all collection fees and all attorneys' fees of Henry Martinez, MD, PA for such action'

REFERRALS

I understand that I am responsible for obtaining a valid referral form from my primary care physician if required by my insurance company.

PRE-CERTIFICATION

I understand that Henry Martinez, MD, PA is obligated to obtain pre-certification for me and it is my responsibility to obtain or make sure that any required pre-certification has been obtained for me prior to my procedure.

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

I agree to promptly pay all charges when billed for medical services rendered. As a parent or guardian, I agree legal responsibility for all charges incurred by the patient named on the previous page. We are permitted to use and disclose your medical information to bill and collect payment for the services we provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. That form will contain medical information, such as a description of the medical services provided to you, that your insurer or HMO needs to approve payment to us.

POLICY CONCERNING MEDICAL RECORDS

I hereby authorize Henry Martinez, MD, PA to release my medical information as I have directed. Therefore, such record copying may be subject to a copying charge. If there is a charge for copying medical records, I understand that I will be billed based upon allowed charges under current laws for copying medical records. Patients or other parties authorized by the patient to request medical records for legal issues, insurance, disability (not workman's compensation), physician change or relocation from the area are subject to a copying charge. There will be no charge for copying records for a referral to another physician made by Henry Martinez, MD, PA, or any other situations covered by Texas law.

PATIENT RIGHT TO PRIVACY/CONFIDENTIALITY

Henry Martinez, MD, PA, is committed to HIPPA privacy rules that apply to all protected health information (PHI) in this office; including information stored and transmitted electronically, paper records and oral communications. In keeping with HIPPA compliance, this office has appointed a privacy officer to continually evaluate our privacy practices. However, from time to time we may need to contact you at home or at work. If we need to contact you, may we have permission to leave a message with regard to your care and appointment information, if you are unable to answer the phone? If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Mr. Joel Martinez, Privacy Officer
201 Oak Drive South, Suite 202
Lake Jackson, Texas 77566
979.297.3098

I authorize/request Henry Martinez, MD, PA to {please initial your choice)

Leave a message at work _____ Yes _____ No
Leave a message at home _____ Yes _____ No

Date: _____ X _____

Patient, Parent or Guardian Signature