ROCKWALL SURGICAL SPECIALISTS
PATIENT REGISTRATION FORM

_____ _____ _____ _____
Patient's Name (Last, First, Middle Initial) Date of Birth Social Security Number Driver's License Number

_____
Mailing Address

_____ _____ _____
City State Zip Code

_____ _____ _____
Home Phone ☐ Preferred Cell Phone ☐ Preferred Work Phone ☐ Preferred

_____ • May we email you? ☐ Yes or ☐ No
Email

May we leave a detailed message: ☐ Yes or ☐ No Preferred Language Spoken: ☐ English ☐ Spanish ☐ Other _____

Marital Status:
☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Legally Separated

Sex:
☐ Male
☐ Female

Race:
☐ White/ Caucasian
☐ Black or African American
☐ Asian
☐ American Indian
☐ Other: _____

Ethnicity:
☐ Hispanic/ Latino
☐ Not Hispanic
☐ Other: _____

PCP/ Family Physician: _____ Referring Provider/ Hospital: _____

How did you hear about our office? _____

_____ _____ Is this Worker's Comp? ☐ YES or ☐ NO
Employer's Name Employer's Phone Number

Occupation/ Job Title? _____ How long? _____

_____ _____ _____
Primary Insurance Company ID Number Group Number

_____ _____ _____
Policy Holder's Full Name Policy Holder D.O.B. Relationship to Patient

_____ _____ _____
Secondary Insurance Company ID Number Group Number

_____ _____ _____
Policy Holder's Full Name Policy Holder D.O.B. Relationship to Patient

Patient Signature:_____ ***Date: _____***

PATIENT MEDICAL HISTORY/INFORMATION

Patient Name: _____ **DOB:** _____

Chief Complaint: _____ O**nset:** _____

Do you have a personal history of:

___High Blood Pressure ___Heart Disease ___Hepatitis ___Blood Clots/ DVT
___Cancer ___Breast Disease ___HIV/AIDS ___Pulmonary Embolism
___Diabetes ___High Cholesterol ___Blood Transfusion ___Sleep apnea
___Thyroid Disease ___Malignant Hyperthermia ___Oxygen Use ___Dialysis Treatment
__ Other: Please specify _____

Family History (Please list): _____

Please List ALL of your previous surgeries: ☐ See Attached List ☐ No Surgical History

SURGERY	YEAR	SURGERY	YEAR
1._____		4._____	
2._____		5._____	
3._____		6._____	

Last colonoscopy? _____ Last EGD? _____ Height: _____ Weight: _____ BMI:_____

Please list ALL current medications, dose, amt/day: ☐ See Attached List ☐ No Current Medications

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

Do you take any blood thinners? (Coumadin, Warfarin, Plavix, Xarelto, Aspirin, etc.)_____

Please list your drug allergies: _____ ☐ NONE

Pharmacy Preference: _____

Location/Town: _____ Phone number: _____

Do you:

___ Smoke/ Tobacco? How long? _____ ___Have you ever used Tobacco? How long? _____
___ Drink Alcohol? How much/often? _____ ___ Diet pills? What kind? _____
___ Do drugs? What/ How long? _____ ___ Have you ever used drugs? _____

Have you recently had any of the following symptoms? (check all the apply)

___Nausea/Vomiting ___Weight loss ___Weight gain ___Chest pain
___Fever/Chills ___Seizure ___Change in appetite ___Heart palpitations
___Weakness ___Double vision ___Abdominal pain ___Heart murmur
___Bleeding problems ___Vision changes ___Blood in stool ___Leg swelling
___Swollen glands ___Earache ___Constipation ___Edema
___Difficulty swallowing ___Headache ___Hemorrhoids ___Nipple discharge
___Acid reflux/heart burn ___Nose Bleeds ___Abdominal mass ___Breast lump
___Depression ___Hearing loss ___Blood in urine ___Rash
___Painful joints ___Itching ___Painful urination ___Change in mole
___Neck pain ___Diarrhea ___Shortness of breath ___Immune problems
___Jaundice ___Pneumonia ___Asthma ___Allergy to iodine

***Patient Signature:*_____ *Date:* _____**

PLEASE NOTIFY US IF ANY OF THE ABOVE INFORMATION CHANGES AT FUTURE VISITS.

Name: _____ **DOB:** _____

BREAST HEALTH QUESTIONNAIRE

Current breast complaint:_____

Previous breast problems? ___ Yes ___ No

If yes, diagnosis/date:_____

Previous breast biopsy? ___ Yes ___ No

If yes, diagnosis/date:_____

Previous breast surgery? ___ Yes ___ No

If yes, procedure/date:_____

Date of last mammogram: _____ Was your mammogram normal? ___ Yes ___ No

Family history of breast cancer? ___ Yes ___ No Ovarian Cancer? ___Yes ___ No

If yes for either breast or ovarian cancer, please complete table below:

Relative	Breast (Check if yes)	Age at diagnosis	Ovarian (Check if yes)	Age at diagnosis
Mother				
Sister				
Daughter				
Maternal grandmother				
Maternal aunt				
Paternal grandmother				
Paternal aunt				
Other:_____				

Other cancers in the family: _____

Reproductive history

Menstrual History: ___ Regular ___ Irregular ___Stopped Date of last menstrual cycle:_____

Age of onset of menses: _____

Number of Pregnancies: _____ Number of live births: _____ Age at first live birth:_____

Did you breastfeed? ___Yes ___No If yes, cumulative duration: _____

Oral Contraceptives: ___Yes ___ No If yes, prescription name: _____

Current use: ___ Yes ___ No Duration: _____

Hysterectomy: ___Yes ___No Date: _____ Ovaries removed: ____ Left ____Right ____Both

Hormone replacement therapy: ___ Yes ___ No If yes, prescription name: _____

Current use: ___ Yes ___ No Duration:_____

ROCKWALL SURGICAL SPECIALISTS

DAVID RITTER, MD ▪ ASHLEY EGAN, MD ▪ JON HARRIS, MD ▪ JOSHUA MARK, MD
PH: (972) 412-7700 FX: (972) 412-7710

HIPAA PATIENT ACKNOWLEDGMENT FORM

In signing this HIPAA Patient Acknowledgment form, I acknowledge and authorize, that I hold harmless this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring from this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this Healthcare Facility is in actual receipt of a signed revocation or until the records retention period required under federal and state laws has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I may inspect a copy of my PHI to be used or disclosed under this authorization; that this Healthcare Facility has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization. A copy of this signed, dated authorization shall be as effective as the original.

Consent to release Protected Health Information (PHI)

I understand that in order to disclose my PHI, Rockwall Surgical Specialists must have my consent, therefore, I authorize Rockwall Surgical Specialists to disclose my PHI as described in the above forms, to the recipients listed below:

Description of the information to be disclosed (Check all that apply):

☐ All PHI Information ☐ Test results ☐ Appointments ☐ Other ☐ Surgery Information ☐ Billing/Account information

Please list the name(s) of the person(s) authorized to obtain the above-mentioned information.
(e.g. Physician other than your referring doctor, family members and other specified person(s))

Emergency Contact?

Name:_____ Relationship:_____ Phone:_____ ☐

Name:_____ Relationship:_____ Phone:_____ ☐

Name:_____ Relationship:_____ Phone:_____ ☐

Name:_____ Relationship:_____ Phone:_____ ☐

Name:_____ Relationship:_____ Phone:_____ ☐

I hereby authorize Rockwall Surgical Specialists to contact me with information, results, or questions, and I acknowledge if I choose to have my information emailed there is a risk of breach.

Printed Patient Name: _____

Patient Signature:_____ Date: _____

Patient representative: (Print name and sign) _____

Relationship to patient: _____ Power of Attorney? ☐ Yes or ☐ No Date: _____

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ASSIGNMENT OF BENEFITS

I consent for Dr. David Ritter, Dr. Ashley Egan, Dr. Jon Harris, Dr. Joshua Mark, and staff to render consultation and treatment. I understand that if I am a minor, a parent or legal guardian must be present at the time of consultation. I, the undersigned, certify that I or my dependent, have insurance coverage and that I have provided that information. I also understand that it is MY RESPONSIBILITY to keep the information updated. I understand there is the possibility that Out-of-Network Provider(s) may provide all or part of the Covered Services. You may contact your insurance company for more information. I assign directly to the above-mentioned physician all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize the physician to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for all procedures and others pay a percentage of the charges. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

If this account is assigned to an attorney for collections and/or suit, the practice shall be entitled to reasonable attorney fees and cost of collections. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health plans to the practice named on this form. The assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

In the course of your treatment from Dr. David Ritter, Dr. Ashley Egan, Dr. Jon Harris, or Dr. Joshua Mark, you may be referred to, or certain procedures may be performed at a facility that the physician may have a financial interest in. By signing this disclosure, you acknowledge the physician's possible financial interest in this facility and your election to use such facility. You are not required to use any of these facilities and have the option to use an alternative health care facility. Please let us know if you have any concerns regarding the relationship between the physician and facilities.

We would like to inform you that if you are required to have a surgical procedure or medical treatment by Dr. David Ritter, Dr. Ashley Egan, Dr. Jon Harris, or Dr. Joshua Mark the fees that are quoted to you from this office are for the services rendered by our office only. You will need to discuss laboratory, pathology, anesthesiology, and facility charges with those individuals. They each have a separate billing office and have NO AFFILIATION with our office. The amount you are requested to pay at the time of scheduling is an estimated amount, due to your insurance benefits. After the surgical procedure or medical services are preformed, your insurance company will be billed. If there is any remaining balance that you are required to pay, you will receive a statement from our office with that amount on it. By signing this form, you acknowledge that you are responsible for any balances on your account and or any services not covered by your insurance company. I have read the above statement and agree that if my insurance company fails to pay, I accept responsibility for charges incurred.

I have read and understand the above disclosure.

PRINTED PATIENT NAME: _____

RESPONSIBLE PARTY SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____ **DATE: _____**

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FMLA/Short Term Disability Release of Information Authorization

I, _____, here by authorize Rockwall Surgical Specialists (physicians and staff) to release any information requested from my employer, human resource department, insurance company, or disability company that is in regard to my time off work request, family leave forms (FMLA), disability payments, or time off compensation.

I also understand that at any time I can revoke this authorization by submitting a request in writing. If I need to re-instate this authorization, I must sign a new form with a current date and this request must be presented in person (by the patient) for authenticity.

PRINTED PATIENT NAME: _____

RESPONSIBLE PARTY SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____ **DATE: _____**

OFFICE LOCATIONS

PLEASE NOTE WE HAVE OFFICES IN 5 DIFFERENT LOCATIONS FOR YOUR CONVENIENCE. IF YOU HAVE QUESTIONS REGARDING WHERE YOUR OFFICE APPOINTMENT IS LOCATED, PLEASE DO NOT HESITATE TO CALL AND CONFIRM. **Main Office Phone: (972) 412-7700**

Rockwall – In Rockwall Medical Center Building at the corner of Ralph Hall & Summer Lee

1005 W Ralph Hall Pkwy
Suite 211
Rockwall, Texas 75032

Rowlett – Behind Lake Pointe Hospital in the 2-story red brick medical building

6705 Heritage Parkway
Suite 104
Rockwall, TX 75087

Forney – In the same suite as Airrosti Pain Management, next to HEENA Salon

375 Marketplace Blvd
Suite 190
Forney, Texas 75126

Greenville – In the Baylor Scott & White Health Center Building

4400 IH-30 West
Suite 300
Greenville, Texas 75402

Terrell – In the Baylor Scott & White Health Center Building

200 N Virginia Street
Terrell, Texas 75160