NORTH TEXAS VASCULAR CENTER
Rizwan H. Bukhari, M.D. FACS

3220 Gus Thomasson Road, Suite #231
Mesquite, Texas 75150
Phone: 972-885-8346 Fax: 214-466-1976

Patient Registration Form (Please Print & Complete Entire Form)

Date: _____ / _____ / _____

PATIENT INFORMATION

Name _____
Last First Middle Initial

Address _____
Street City State Zip Code

Birthdate: _____ - _____ - _____ S. S. # _____ - _____ - _____

Email Address: _____ Cell Phone: ( ) -

Home Phone: (_____)_____ Work Phone: ( ) -

Driver's License # _____ Sex: ( ) M ( ) F

Employer/School: _____

If the patient lives in a nursing home, please provide the name, address and telephone number of the facility:

Name of Facility: _____

Address: _____

Facility Phone: _____ Contact Person: _____

Primary Language Spoken: _____

Ethnicity (Circle One): White/Caucasian Black/African American Hispanic/Latino
Not of Hispanic Origin American Indian/Alaskan Native Hawaiian/Pacific Islander
Patient Refused to Report

Referring Physician: _____ Phone Number: _____

Primary Care Physician: _____ Phone Number: _____

(1) Emergency Contact: _____ Relation: _____

Contact Phone#: _____

(2) Emergency Contact: _____ Relation: _____

Contact Phone#: _____

INSURANCE INFORMATION

Primary Insurance: _____

Subscriber # _____ Group # _____ Plan # _____

Policy Holder: _____ Relation to Patient: _____

Birthdate: ____ - ____ - ____ Social Security#: ____ - ____ - ____

Secondary Insurance: _____

Subscriber # _____ Group # _____ Plan # _____

Policy Holder: _____ Relation to Patient: _____

Birthdate: ____ - ____ - ____ Social Security#: ____ - ____ - ____

Tertiary Insurance: _____

Subscriber # _____ Group # _____ Plan # _____

Policy Holder: _____ Relation to Patient: _____

Birthdate: ____ - ____ - ____ Social Security#: ____ - ____ - ____

ASSIGNMENT and RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with: _____

(Name of Insurance Company)

and am/are assigned directly to Dr. Rizwan H. Bukhari, MD. I, the undersigned, hereby authorize and direct my insurance carrier to pay directly to Dr. Rizwan H. Bukhari, MD all insurance benefits, if any, due to me under by insurance plan. I further agree to pay the balance the charges not paid by my insurance. Any balance that is not paid within 45 days will also be my responsibility. I hereby authorize the release of any information necessary to secure payment of benefits. I also authorize the use of this signature on all insurance submissions. If the patient is a minor, I as a legal guardian give consent for treatment for this and future services rendered. I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **(Date)**

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative **Relation to Patient**

PATIENT'S CONFIDENTIAL HEALTH HISTORY

Reason for your visit today? _____

_____

SYMPTOMS — Check(√) symptoms you currently have or have had in the past year.

GENERAL

( )Depression
( )Dizziness
( )Fainting
( )Fever
( )Forgetfulness
( )Headache
( )Loss of Sleep
( )Loss of Weight
( )Nervousness
( )Numbness

CARDIOVASCULAR

( )Chest Pain
( )High BloodPressure
( )IrregularHeart Beat
( )Low Blood Pressure
( )Poor Circulation
( )Rapid Heart Beat
( )Swelling of ankles
( )Varicose Veins
( )Blood Thinners
( )Blood Vessel Stents ( )No ( ) >6 months ago

Location:_____ **Date:**_____

Pain in the…

( )Hips
( )Legs
( )Neck
( )Shoulders

EYE, EAR, NOSE, THROAT

( )Blurred Vision
( )Crossed Eyes
( )Difficult Swallowing
( )Double Vision
( )Vision Flashes
( )Vision Halos

GASTROINTESTINAL

( )Appetite Poor
( )Bloating
( )Bowel Changes
( )Constipation
( )Diarrhea
( )Gas
( )Indigestion
( )Nausea
( )Rectal Bleeding
( )Stomach Pain
( )Vomiting
( )Vomiting Blood

PREDIALYSIS OR DIALYSIS

( ) M - W - F
( ) T - Th - S

_____
Date Dialysis Begin

_____
Dialysis Facility Name

( ) -
Dialysis Facility Phone

_____
Nephrologist Name

( ) -
Nephrologist Phone

_____
Cardiologist Name

( ) -
Cardiologist Phone

CONDITIONS — Check (√) conditions you currently have or have had in the past year.

( )AIDS
( )Alcoholism
( )Arthritis
( )Asthma
( )Cancer
( )High Cholesterol
( )HIV Positive
( )Kidney Disease
( )Pacemaker
( )Heart Disease
( )Psychiatric Care
( )Stroke
( )Suicide Attempt
( )Ulcers
( )Diabetes

FAMILY HISTORY

Grandfather: Alive / Dead Cause of Death: _____ Age: _____

Grandmother: Alive / Dead Cause of Death: _____ Age: _____

Father: Alive / Dead Cause of Death: _____ Age: _____

Mother: Alive / Dead Cause of Death: _____ Age: _____

Other Family Illnesses:

_____
_____
_____
_____

ALLERGIES

1) _____

2) _____

3) _____

4) _____

_____
Pharmacy Name

_____
Pharmacy Phone

HOSPITALIZATIONS and SURGERIES

YEAR	HOSPITAL	REASON FOR HOSPITALIZATION AND OUTCOME	PHYSICIAN

Have you ever had a blood transfusion? **YES** **NO**

If yes, please give approximate dates. _____

HEALTH HABITS

Check (√) which you use and how much you use.

( ) Caffeine	
( ) Tobacco	
( ) Street Drugs	
( ) Other	

OCCUPATIONAL HABITS

Check (√) if your work exposed you to:

( ) Stress
( ) Heavy Lifting
( ) Hazardous Substance
( ) Other

Occupation: _____

(If retired, what did you do prior to retirement)

How long have you worked there? _____

Do you have a living will? **YES** **NO**

Do you have a durable power of attorney for healthcare? **YES** **NO**

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative (Date)

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relation to Patient

_____ _____

Reviewed By (Office Staff) (Date)

MEDICATION LIST

Patient Name: ____

Medication Name	Dosage	Frequency	Current	Inactive

PATIENT'S PHYSICIAN LIST

PLEASE LIST BELOW ALL THE DOCTORS YOU SEE ON A REGUALR BASIS
(Example: Primary Care, Cardiologist, Nephrologist, Urologist, Obstetric/Gynecologist, etc.)

Physician: ______________________
First and Last Name

Specialty: ______________________

Address: ______________________

____

Phone #: ______________________

Fax #: ______________________

Physician: ______________________
First and Last Name

Specialty: ______________________

Address: ______________________

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Phone #: ______________________

Fax #: ______________________

Physician: ______________________
First and Last Name

Specialty: ______________________

Address: ______________________

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Phone #: ______________________

Fax #: ______________________

Physician: ______________________
First and Last Name

Specialty: ______________________

Address: ______________________

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Phone #: ______________________

Fax #: ______________________

Physician: ______________________
First and Last Name

Specialty: ______________________

Address: ______________________

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Phone #: ______________________

Fax #: ______________________

Physician: ______________________
First and Last Name

Specialty: ______________________

Address: ______________________

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Phone #: ______________________

Fax #: ______________________

Physician: ______________________
First and Last Name

Specialty: ______________________

Address: ______________________

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Phone #: ______________________

Fax #: ______________________

Physician: ______________________
First and Last Name

Specialty: ______________________

Address: ______________________

____

Phone #: ______________________

Fax #: ______________________

PATIENT FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following policy. If you have and questions, please discuss them with the Office Administrator. We are dedicated to providing the best possible care and services to you, and regard your complete understanding of financial responsibility to be an essential element of your care and treatment.

Payment for all services rendered is due in full at the time of service for all patients that are non insured and for insurances that require deductibles be met before payment. All copays, deductibles and coinsurances are due at the time of service.

_____
Initials

We are participating providers with most insurance plans and will submit claims directly to them for payment. The patient will need to assign benefits to the doctor, in other words, the patient agrees to have their insurance company pay the doctor directly. If North Texas Vascular Center is not a participating provider of the patient's Health Plan, full payment is due at the time of service. For your convenience we accept VISA, Master Card, AMEX and Discover.

_____
Initials

All health care plans are not the same and do not cover the same services. In the event the patient's Health Care Plan determines that a service is "not covered" and does not pay for services provided, the patient is responsible for all charges for services provided. Payment is due in full at the time of service or upon notice of insurance claim denial and/or upon receipt of statement from our office.

_____
Initials

For all services provided in the hospital, we will bill your health plan. Any remaining balance due will be the responsibility of the patient and due upon receipt of a statement from our office.

_____
Initials

In order to provide the best possible service and availability to our patients, please call as early as you know that you will need to reschedule and appointment with our office. **Missed, cancelled and/or No Show appointments without 24 hour notice may result in the patients account being charged a $50.00 fee.**

_____
Initials

Please note that there will be a $45.00 charge to all patients requiring completion of FMLA or insurance claim paperwork and/or requests for Medical Records.

_____
Initials

Please note that there will be a $35.00 charge for all returned checks.

_____
Initials

******* Please notify us of any changes in your information, such as name change, insurance, address, phone numbers, emegency contact, dialysis centers, nursing homes, rehabilitation centers, primary care and/or specialist physisicans. *******

I have read and understand the financial policy of North Texas Vascular Center and agree to be bound by these terms. I understand and agree such terms may be amended at any time by the practice.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative **(Date)**

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative **Relation to Patient**

CONSENT to RELEASE PROTECTED HEALTH INFORMATION (PHI)

I, _____, (Patient Name) understand that in order to disclose my Protected Health have my consent. Therefore, I authorize North Texas Vascular Center to disclose my Protected Health Information (PHI) as described on this form, to the recipients listed below; The description of the information to be disclosed.

Please check all that apply:

( ) All Procedures ( ) Lab Results ( ) Medical Notes

( ) Other: _____

Please list all individuals who may have access to your Protected Health Information (PHI):

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

OR

_____ **I DO NOT** authorize North Texas Vascular Center to release my Protected Health Information (PHI) to anyone other than myself. I fully understand that by doing so that it may take longer to get my results.

Signature of Individual or Legal Representative Witness: _____ _____
(Date)

Printed Name of Individual or Legal Representative Witness: _____

HIPAA PRIVACY RULE RECEIPT of NOTICE of PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

North Texas Vascular Center- Mesquite, Texas
Acknowledgement of receipt of information Practices Notice

I, _____ (**Patient's Name**) have received and understand North Texas Vascular Center, Mesquite, Texas Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and North Texas Vascular Centers' legal duties with respect to my information.

Signature of Individual or Legal Representative Witness: _____ _____
(Date)

Printed Name of Individual or Legal Representative Witness: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

( ) Individual refused to sign
( ) Communication barrier prohibited obtaining the acknowledgement
( ) An emergency situation prevented us from obtaining acknowledgement
( ) Other (please specify): _____

Privacy Official: _____ _____
(Signature) (Date)

_____
(Printed Name)