Hillcrest Medical

8611 Hillcrest Avenue, Suite 180, Dallas Texas 75225
Telephone: 214-368-3800❖Fax: 214-360-7724❖www.hillcrestfamilymedical.com

Patient Information

Date: _____ Complaint: _____

Last name: _____ First name: _____ Middle initial: ____

Date of Birth: _____ SSN#: _____ TDL#; _____ Gender: M / F

Address: _____ Apt. #: _____ Married/Single

City: _____ State: _____ Zip: _____

Telephone: _____ Mobile: _____ email: _____

Patient Responsibility

Responsible Party: _____ Relationship to Patient: _____

Last name: _____ First name: _____ Middle initial: ____

Date of Birth: _____ SSN#: _____ TDL#; _____ Gender: M / F

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Mobile: _____ email: _____

Employment

Employer: _____ Website/email: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Mobile: _____ email: _____

Insurance

Insurance: _____ Policy #: _____

Group #: _____ Policy Holder: _____

Relation to patient: _____ Employer: _____

Telephone: _____ Mobile: _____ email: _____

Emergency Notification

Person to Notify: _____ Relationship: _____

Telephone: _____ Mobile: _____ email: _____

Address: _____

**How did you find out about our office? _____

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New Patient Questionnaire

Name: _____ Date of Birth: _____

Reason for Visit: _____

Medical History

__ High Cholesterol
__ High Blood Pressure
__ Heart Murmur
__ Asthma
__ Angina/Chest Pains
__ Heart Attack/MI
__ Heart Failure/CHF
__ Palpitations
__ Hepatitis/Jaundice
__ Hernia
__ Kidney Stones
__ Emphysema/COPD
__ Prostate Disorders
__ Menstrual Problems
__ Diabetes
__ Arthritis
__ Skin Conditions
__ Leg Swelling/Phlebitis
__ Blood Clots
__ Ulcer/Gastritis/GERD
__ Indigestion/Heartburn
__ Colitis/Colon Polyps
__ Diarrhea/Constipation
__ Hemorrhoids/Bleeding
__ Sinus Infections
__ Allergy/Hay Fever
__ Urinary Tract Infections
__ Chronic Fatigue
__ Tuberculosis
__ Pelvic Pains
__ Back Pain
__ Anemia
__ Thyroid Disorders
__ Stroke
__ Seizures
__ Migraines/Headaches
__ Depression/Anxiety/Panic
__ Dementia/Memory Loss
__ Cataract/Glaucoma
__ Dizzy/Vertigo
__ Syncope/Fainting
__ Pneumonia
__ Venereal Disease
__ Erectile Dysfunction
__ Chronic Cough
__ Cancer
__ Arthritis
__ Skin Problems

Surgical History: _____

Hospitalizations: _____

Major Injuries/Fractures/MVA: _____

Blood Transfusions: __ Yes __ No
Smoking History: __ Yes __ No Packs/day: ____ Years: ____ Date Quit: _____
Alcohol History: __ Yes __ No Daily: ___ Socially: ____ Rarely: ____ Never: _____

Occupational History: _____

HIV/AIDS: __ Yes __ No
Fear of Violence at Home/Work __ Yes __ No

Medications/Dosage: _____

Medication/Drug Allergies: _____

Family History:

__ Hypertension
__ Diabetes
__ Thyroid Disease
__ High Cholesterol
__ Cancer
__ Stroke
__ Glaucoma
__ Depression
__ Heart Disease
__ Tuberculosis
__ Arthritis
__ Mental Illness

Are Parents Living __ Yes __ No

Have you had:

__ Annual Physical __ EKG __ Chest X-ray __ Lab Work __ Flu Shot __ Colonoscopy
__ Cardiac Stress Test __ PFT(Pulmonary Function Testing) __ HIV/STD Testing

Females Only:

Last Menses: _____ Gynecologist: _____
Last Pap Smear: _____ Last Mammogram: _____Pregnancies: # ___ Live Children: # _____

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment and or other Healthcare Operations.

I, _____, understand that as part of my health care, Hillcrest Medical originates and maintains paper and electronic records describing my health history, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:
A basis for planning my care and treatment, a means of communication among health care professionals who contribute to my care, a source of information for applying my diagnosis and surgical information to my bill, a means by which a third party payer can verify that services billed were actually provided, a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges: The right to review the notice prior to signing the consent, and the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, and or other healthcare operations.

I understand that Hillcrest Medical is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, Hillcrest Medical may refuse to treat me as permitted by Section 164.506 of the code of Federal Regulations.

I understand that as part of this organization's treatment, payment and or other healthcare operations, it may become necessary to disclose my protected health information to another entity, and hereby consent to disclose for those permitted uses, included disclosures via fax or email.

I understand that I will receive separate, and or additional billings when outside Radiology and Laboratory professionals are required to evaluate testing done at Hillcrest Medical. Hillcrest Medical does not set the fee schedules for these services, however we will make every effort to make sure the bills are accurate and reasonable for services rendered.

I wish to have the following restrictions to the use or disclosure of my health information:
_____

I fully understand and accept/decline the terms of this consent,

_____ Date: _____
Patient/Gaurdian Signature

FOR OFFICIAL USE ONLY

Consent received by _____ on _____

Comments: _____

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Assignment of Benefits Form

Financial Responsibility
All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits
I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to Marlon Padilla, M.D., P.A. medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information
I hereby authorize Marlon Padilla, M.D., P.A. to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Marlon Padilla, M.D., P.A. on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____
Patient/Responsible Party Signature Date

_____ _____
Witness Date