Edward Holt, DO P.A

Patient Information

Nombre: _____ **Edad:** _____ **Fecha de Nacimiento:** _____ **Seguro Social:** _____

Direccion: _____ **Ciudad:** _____ **Estado:** _____ **Codigo:** _____

Telefono de Casa: _____ **Celular:** _____ **# de Trabajo:** _____

Doctor Familiar: _____ **Compania de Trabajo:** _____ **Ocupacion:** _____

Direccion de Trabajo: _____ **Ciudad:** _____ **Estado:** _____ **Codigo:** _____

Estado Civil: (circula uno) Soltera Casada Divorciada Viuda **Raza:** Indio Americano Chino Negro Hispano Blanco Otro_____

Como se entero de nuestra oficina? _____ **Que farmacia utiliza y donde?** _____

PERSONA QUE AVISAR EN CASO DE UNA EMERGENCIA

Nombre: _____ **Relacion:** _____

Telefono de Casa: _____ **Celular:** _____ **# de Trabajo:** _____

INFORMACION DE ESPOSO(A)

Nombre: _____ **Seguro Social:** _____ **Fecha de Nacimiento:** _____

Compania de Trabajo: _____ **Numero de Trabajo:** _____ **Celular:** _____

Direccion de Trabajo _____ **Ciudad:** _____ **Estado:** _____ **Codigo:** _____

INFORMACION DE ASEGURANSA

Nombre de Aseguransa: _____ ID#: _____ Grupo#: _____

Nombre del Tomador de Seguro: _____ Fecha de Nacimiento: _____ Relacion con paciente: _____

Aseguransa Segunda: _____ ID#: _____ Grupo#: _____

Nombre del Tomador de Seguro: _____ Fecha de Nacimiento: _____ Relacion con paciente: _____

ASIGNACION Y LIBERACION: Yo asigno mis beneficios de seguro a pagar directamente al medico. Tambien autorizo el medico para liberar toda la informacion contenida en mis registros medicos y financieros a mi compania de seguros o plan de salud, o cualquier otra persona o entidad que se encarga de pagar o procesamiento de pago alguna parte de mi factura. Entiendo que soy totalmente responsable por el pago de todas las tarifas y servicios prestados. Permitir la copia

ASIGNACION DE BENEFICIARIOS DE MEDICARE Y LIBERACION: Yo solicito pago de prestaciones de Medicare autorizados a mi o a mi nombre para cualquiera de los servicios me proporcionados por Edward L. Holt, DO, P.A.. Autorizo a cualquier informacion necesaria para determinar estos beneficios o prestaciones de servicios relacionados de esta autorizacion para utilizar en lugar del original.

OBLIGACION FINANCIERA: Por lo presente reconzco y entiendo que pueden haber ser servicios siempre no sera cubierto por mi compania de seguros y entender que estoy totalmente responsible por el pago de todas las tarifas y servicios prestados, independientemente de la cobertura de seguro o otras responsabilidades y en ultima instancia responsible por el pago en su totalidad si mi compania de seguros no pagan oportunamente.

EL CONSENTIMIENTO PARA EL TRATAMIENTO: Autorizo al medico, enfermeras, asistentes medicos y personal para llevar a cabo dichos examines y administrar tratamiento y medicamentos que consideren necesario y conveniente.

He leido cada una de las declaraciones por encima y autorizar, entender y de acuerdo a cada declaracion.

Firma del Paciente: _____ **Fecha:** _____

Edward Holt, DO P.A
HISTORIA DEL PACIENTE

Cirugias: (Lista **TODAS** las cirugias que has tenido)

1._____ 3._____

2._____ 4._____

MEDICAMENTOS: (Lista **TODO** los medicamentos que tomas regularmente y mas recientes, incluyendo todos los medicamentos sin receta)

1._____ 3._____

2._____ 4._____

ALERGIAS: Eres alergico alguna medicina, drogas, o comida? (Si acaso Si, lista cuales son tus reaciones)

_____

_____

HISTORIA DE ANTICONCEPTIVOS: (Lista todo los metodos de anticonceptivo actuals o pasados que has usado.)

	Metodo de Tipo	Duracion de Uso	Complicaciones
Presente	_____	_____	_____
Pasado	_____	_____	_____
	_____	_____	_____

HISTORIA OBSTRETICA: (Liste todo los embarazos, fecha, y resultados)

Fecha	Peso	Sexo	Lugar del Parto	Tipo de Parto	Complicaciones
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

HISTORIA DE FAMILIA: (Liste miembros de su familia (papa, mama, hermana, hermano, etc.) con algun problema de salud.)

_____

_____

HISTORIA SOCIAL:

Ha fumado alguna vez? ☐ Si ☐ No Cuanto/dia? _____ Por cuantos anos? _____

Alcohol: ☐ Si ☐ No Cuantas bebidas/dia? _____ Por semana? _____

Hace ejercisios? ☐ Si ☐ No Ha usado drogas recreativas? ☐ Si ☐ No Especifique: _____ Por favor, cuantificar el consumo de cafeina: _____ Alguna vez has sido abusada sexualmente, amenazada o herida por cualquier? ☐ Si ☐ No

HISTORIA GINECOLOGICA:

HISTORIA MENSTRUAL:

Primer dia de su ultima menstruacion_____ Edad cuando comenso su primera menstruacion: ____ Numero normal de dias de un period a otro:_____

de dias de flujo: _____ Sus periodos son: ☐ Ligeros ☐ Moderado ☐ Devil Alguna abnormalidad con periodo? _____

Cualquier sangrado o manchas excesivas? ☐ Si ☐ No Colicos con periodos ☐ Si ☐ No

SEXUAL HISTORY:

Alguna vez has tenido relaciones sexuales? ☐ Si ☐ No Es usted sexualmente activa? ☐ Si ☐ No # de parejas sexuales por vida? ____

Cualquier historia de enfermedades de transmision sexual? _____ Sus companeros sexuales son: ☐ Hombre ☐ Mujer ☐ Los Dos ☐ No applicable.

Pecho

___Masa en el pecho ___Dolor en el pecho
___Secrecion en el pezon

Neurologico

___Difficultad para caminar ___Mareo
___Dolor de cabeza ___Problemas de memoria
___Paralisis ___Ataques
___Temblor

Psiquiatrico

___Ansiedad ___Depresion
___Llanto frecuente

Endocrino

___Crecimiento anormal de vello ___ Sed anormal
___Profundizacion de voz ___Perdida de cabello
___Intolerancia ___Bochornos

Instrucciones Confidenciales del Paciente

Nombre del Paciente:_____ Fecha de Nacimiento:_____

Es importante para nosotros, para honrar la confidencialidad entre paciente y medico.

Por favor escoja su preferencia a continuacion.

_____ Usted puede discutir mi informacion media solo conmigo.

_____ Doy mi permiso para hablar de mi informacion medica con las siguientes personas:

Nombre_____ Relacion_____

Nombre_____ Relacion_____

Nombre_____ Relacion_____

Si o NO Usted puede dejar la informacion (resultados de prueba) en mi buzon:

Casa#:_____ Celular #:_____

Firma del paciente:_____ Fecha:_____

Edward L. Holt, DO, P.A.
OBSTETRICAL DEPOSIT & PAYMENT AGREEMENT

FINANCIAL POLICY

1. Your insurance will be filed as a courtesy to you; however, you are responsible for the entire bill. All co-pays, unmet deductibles, and other patient responsible services must be paid on the day of the visit. If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. If you do not have insurance, payment in full will be expected at the time of the visit.
2. In the event your insurance company does not pay the claim within a reasonable amount of time (45-60 days) then you may become responsible for the bill.
3. If your insurance plan requires a referral or prior authorization, you must present this along with insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.
4. If payment is not received within a reasonable amount of time from the guarantor or if we receive returned mail as undeliverable we will place your account with an outside collection agency.
5. Returned checks will be subject to a returned check fee.
6. A fee may be charged for missed appointments. Two No Show appointments with no advanced notice from the patient may result in termination from the practice. Being 10 minutes or more late for an appointment may result in rescheduling your appointment.
7. **PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUESTS:** I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of assignment benefits be made on my behalf.
8. **FINANCIAL AGREEMENT**: The undersigned in consideration of the services to be rendered to the patient is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney r agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned agrees to be responsible for charges not covered by insurance. It is understood the obligation to pay the practice may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.
9. **NOTICE OF PRIVACY:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.
   - ☐ I decline the Notice of Privacy Practices

have read and fully understand the Financial Policy and have been given the opportunity to ask questions.

_____ Date: _____

ignature of Patient, Legal Representative for health care services, if other than Patient

_____

Relationship of Representative. Reason individual is unable to sign, i.e. minor or legally incompetent

Patient Name: _____ DOB: _____

2203 West Lampasas, Suite 210. Ennis, TX 75119. Tel: 972.875.2112 Fax: 972.875.6112

Welcome to Dr. Holt's Office

Office Policy effective 10/1/2011

- Absolutely **NO CHILDREN** over the age of twelve (12) months. Failure to comply with policy may result in rescheduling your appointment.
- Only one (1) guest is allowed in the exam room with each patient.
- No food or drinks are allowed in the office.
- Please turn off your cell phones in the Exam Room.

This policy helps to protect the health and safety of our patients.

Patient Signature: _____ Date: _____

Genetic Screening Questionnaire

Name _____ **Race** _____ **Age** _____

Father of Child _____ **Race** _____ **Age** _____

First day of your last menstrual period _____

How many times have you been pregnant, including this time? _____

How many miscarriages have you had? _____

Have you ever had a stillborn child? Yes ____ No ____

Have any of your children died? Yes ____ No ____

Do you have a child with a birth defect? Yes ____ No ____

Have you been exposed to drugs, X-rays, alcohol, or tobacco use during this pregnancy? Yes ____ No ____

If the baby's father has children by another woman, did she have miscarriages, a stillbirth, or children with birth defects? Yes ____ No ____

Are you or the father of Eastern European Jewish origin? Yes ____ No ____

Are you or the father Black? Yes ____ No ____

Are you or the father Greek or Italian? Yes ____ No ____

Are you and the father blood relatives? Yes ____ No ____

Check any of the following disorders that occur in your family or the family of the baby's father

_____Birth defects

_____Childhood/Infancy Deaths

_____Mental Retardation

_____Down's Syndrome

_____Spina Bifida

_____Hydrocephalus

_____Sickle Cell Trait of Disease

_____Polycystic Kidney Disease

_____Tay-Sachs Carrier of Disease

_____Galactosemia

_____Hemophilia (bleeding disorder)

_____Person under 35 with heart disease

_____Person under 35 with emphysema

_____Any disorder or disease that "runs" in the family. What? _____

_____Huntington's Chorea

_____Porphyria

_____Cleft lip or palate

_____Heart defects

_____Blindness

_____Deafness

_____Dwarfism

_____Cystic Fibrosis

_____Thalassemia

_____Phenylketonuria PKU

_____Muscular Dystrophy

_____Diabetes

Edward L. Holt, DO, P.A.
OBSTETRICAL DEPOSIT & PAYMENT AGREEMENT

AGREEMENT FOR NON-COVERED SERVICES

UNDER ALL

CHIP PERINATE INSURANCE PLANS

RESPONSIBILITY OF PAYMENT

The following services and procedures are NOT COVERED under the Chip Perinate Insurance plan. This list is not all inclusive. Consult your member services department for more information.

- Inpatient and outpatient treatments, *other than* prenatal care, labor with delivery, and postpartum care related to the covered unborn child until birth.
- Services related to preterm, false, or other labor *not* resulting in delivery.
- Nursing care services
- Emergency services other than those directly related to the delivery of the covered unborn child.
- Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate (ex. High blood pressure or diabetes pertaining to the mother).
- Mammography screening

PAYMENT FOR ANY SERVICES AND PROCEDURES THAT ARE NOT PAYABLE BY THE INSURANCE COMPANY WILL BE THE RESPONSIBILITY OF THE UNDERSIGNED PATIENT.

- I understand that I may receive medical services from Dr. Holt that are not covered benefits of my insurance plan.
- I understand that I am responsible to pay for any services received that are not covered benefits of my insurance plan.
- I understand that after a claim has been submitted to my insurance carrier, if (1) the claim is denied for any reason; OR (2) there is additional patient liability (i.e. deductible, co-insurance, or non-covered charges, etc.) the balance is my responsibility.
- I understand that I may establish a payment plan to pay for non-covered medical services.

Patient Signature: _____ Date: _____

Patient Name: _____ DOB: _____

Employee Initials: _____

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OBSTETRICAL DEPOSIT & PAYMENT AGREEMENT

PRIVATE PAY AGREEMENT

I understand that Dr. Holt is accepting me as a private pay patient for the period of _____, and I will be responsible for paying any services I receive. The provider will not file a claim to Medicaid for services provided to me.

Patient Signature: _____ Date:_____

Patient Name: _____ DOB: _____

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