Howard M. Mintz M.D., F.C.C.P.

*Patient Registration

PATIENT INFORMATION

Patient Name: ________________________________ Date of Birth: _____________________

Home Address: ____
Street Apartment # City State Zip Code

Home Phone #: ________________________ Work Phone #: ___________________________

Cell Phone #: _________________________ Best Contact # (circle one): Home Work Cell

Email: ___________________________________@__________________________________

Occupation: ______________ Employer: _____________ Social Security #: ____ --____--____

Marital Status (circle one): Married Divorced Widowed Single

SPOUSE INFORMATION

Spouse Name: _______________________________________ Date of Birth ______________

Employer: ____________________________________ Social Security #: ____ --____--____

Best Contact Number: ____________________

INSURANCE INFORMATION (Please fill everything out even though a copy will be obtained)

Primary Insurance: __________________________________ Specialist Co-pay: $ __________

Policy/ID #: ___________________________________ Group #: _______________________

Policy Holder Name __________________________ Date of Birth ___________________

PolicyHolderAddress____
Street Apartment# City TX Zip Code

Secondary Insurance: ____

Policy/ID #: ___________________________________ Group #: _______________________

MISCELLANEOUS INFORMATION

Emergency Contact: _______________________ Emergency Contact #: __________________

Pharmacy Name: ________________________ Phone Number: _________________________

Primary Physician: ________________________ Referred By: __________________________

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NOTICE OF INSURANCE VERIFICATION AND REFERRALS

I ______________________, the patient, understand that as the consumer of the insurance company, it is my responsibility to verify that my physician is "in network" according to my insurance plan(s) and notify the office of any changes in my insurance coverage. Furthermore it is my responsibility to obtain referrals needed prior to the date of service and ensure my referrals are current on date and number of visitations. If I am seen "out of network" and/or without a referral, I understand my insurance company may not pay for services rendered, and I will be liable for all charges incurred.

_________________________	X______________________________	__________________
Patient Name Printed	Patient Signature	Date

AUTHORIZATION OF DISCLOSURE

I__________________, the patient, authorize the full disclosure of my entire medical record including but not limited to patient histories, office notes, test results, radiology studies, films, studies, consults, alcohol/drug treatment, mental health information, HIV-related information, billing records, insurance records, and records sent by other physicians to the following individuals:

_____________________	________________________	______________________
Name of Individual	Relationship to patient	Contact number
_____________________	________________________	______________________
Name of Individual	Relationship to patient	Contact number
_____________________	________________________	______________________
Name of Individual	Relationship to patient	Contact number

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of the disclosure. Information re-disclosed by the recipients listed in this authorization will not be the liability of the physicians. Authorization may be revoked in part or in full at any time with written authorization by the patient.

_________________________	X______________________________	__________________
Patient Name Printed	Patient Signature	Date

NOTICE OF CHARGE FOR MISSED APPOINTMENTS

Due to the increasing number of missed appointments, our office will charge a **$45.00 fee for a missed appointment** that is not cancelled 24 hours prior to the appointment time.

I acknowledge this policy:

_________________________	X______________________________	__________________
Patient Name Printed	Patient Signature	Date