*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: _____

DALLAS LUNG DOCTORS
Howard M. Mintz, M.D
501 North Central Expressway, Suite 101, Dallas Texas 75231
Phone: (214) 363-8447, Fax:(214) 396-1909

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

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