



Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Social History**

- Recent Travel  Yes  No
- Alcohol  Yes  No
- Recreational drugs  Yes  No
- Marital status  Yes  No
- Smoking  Yes  No

**Family History of Cancer**

- Mother  Yes  No
- Father  Yes  No
- Siblings  Yes  No

**Past Medical History**

- Stroke  Yes  No
- High blood pressure  Yes  No
- Heart disease  Yes  No
- Heart Failure  Yes  No
- Diabetes  Yes  No
- Hyperthyroidism  Yes  No
- DVT  Yes  No
- Pulmonary embolism  Yes  No
- COPD  Yes  No
- Cough  Yes  No
- Keloids  Yes  No
- Abdominal pain  Yes  No
- Chronic diarrhea  Yes  No
- Hepatitis C  Yes  No

- Hepatitis B  Yes  No
- HIV positive  Yes  No
- Renal failure  Yes  No
- Cancer, breast  Yes  No
- Radiation therapy  Yes  No
- Chemotherapy  Yes  No
- Blood transfusion  Yes  No
- Hemophilia A  Yes  No
- Breast lump  Yes  No

**Surgical History**

- No previous Surgery  Yes  No
- Hysterectomy  Yes  No
- Inguinal hernia repair  Yes  No
- Ventral hernia repair  Yes  No
- Cholecystectomy  Yes  No
- Umbilical hernia repair  Yes  No
- Appendectomy  Yes  No
- C section  Yes  No
- Neck mass  Yes  No
- Heart catheterization  Yes  No
- Repair of fractures  Yes  No
- Spinal surgery  Yes  No
- Gastric bypass  Yes  No
- Gastric stapling  Yes  No
- Gastrostomy  Yes  No
- Thyroidectomy  Yes  No
- AAA repair  Yes  No
- Breast biopsy  Yes  No
- Breast reduction  Yes  No
- Breast augmentation  Yes  No
- Colon resection  Yes  No
- Removal of spleen  Yes  No

**Constitutional**

- Recent weight change  Yes  No
- Loss of appetite  Yes  No
- Recent fever  Yes  No
- Weakness  Yes  No
- Fatigue  Yes  No
- Night sweats  Yes  No

**Psychology**

- Depression  Yes  No
- Anxiety  Yes  No
- Eating disorder  Yes  No

**Genitourinary male** (only fill if male)

- Hard testicle  Yes  No
- Groin hernia  Yes  No
- Difficulty urinating  Yes  No

**Genitourinary female** (only fill if female)

- Pelvic pain  Yes  No

**ENT/Respiratory**

- Recent cough  Yes  No
- Recent cold  Yes  No

**Cardiology**

- Shortness of breath  Yes  No
- Murmurs  Yes  No
- Palpitations  Yes  No
- Chest pain  Yes  No
- Swelling of the legs  Yes  No

**Dermatology**

- Rash  Yes  No
- Moles  Yes  No
- Lumps  Yes  No
- Previous skin cancer  Yes  No

**Endocrinology**

- Cold intolerance  Yes  No
- Heat intolerance  Yes  No

**Hematology**

- Easy bleeding  Yes  No
- Swollen glands  Yes  No
- Varicose veins  Yes  No
- Easy bruising  Yes  No

**Gastroenterology**

- Blood in stool  Yes  No
- Diarrhea  Yes  No
- Vomiting  Yes  No
- Constipation  Yes  No
- Nausea  Yes  No
- Difficulty swallowing  Yes  No
- Abdominal pain  Yes  No
- Change in bowel habits  Yes  No
- Frequent heartburn  Yes  No

**Apex Surgical Care, P.A. • Ricardo Lebron Valdez, MD**

929 N. Galloway Ave. • Suite 301 • Mesquite, Texas 75149

**PATIENT INFORMATION**

**Assignment of Benefits/Release of Information/Notice of Privacy Practices/Appointment of Authorized Representative**

**\*\*Please read and initial each paragraph\*\***

\_\_\_\_\_ **Apex Surgical Care, P.A.**, and associated physicians are committed to securing the privacy of your health information. We are supplying you with a copy of our Notice of Privacy Practices. You are not required to read this notice. By initialing, you are acknowledging receipt of this notice.

\_\_\_\_\_ I request that payment of authorized Medicare and other insurance benefits be made on my behalf to **Apex Surgical Care, P.A.** for any services furnished to be by any healthcare providers associated with that group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or insurance company any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_ I appoint **Apex Surgical Care, P.A.** to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

\_\_\_\_\_ Unless I request to the contrary, in writing, I will receive appointment reminders on my home telephone answering system and/or appointment reminder cards sent by mail, whichever is the policy of the practice.

**Patient Financial Responsibility Statement**

In order to maintain our fees at the lowest possible level, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward that end. We encourage you to discuss it with us and to ask questions.

We understand that your health coverage is provided through \_\_\_\_\_  
(Insurance Company)

- If you have out-of-network benefits, we will happily file claims on your behalf.
- You must pay any co-payment and applicable deductible amounts at the time of service unless other arrangements have been made with our office.
- The remainder of your bill will be sent to your health plan for direct payment to our office.
- If your insurance carrier has not paid our claim within 45 days, we will expect payment from you.
- If, by mistake, your health plan remits payment to you, please send it to us along with all paperwork sent to you at the time.
- You will remain responsible for amounts and any services that are not covered by your insurance plan.
- Your health plan may refuse payment of a claim for some of the following reasons:
  - 1) This is a pre-existing illness that is not covered by your plan
  - 2) You have not met your full calendar year deductible
  - 3) The type of medical service required is not covered by your plan
  - 4) The health plan was not in effect at the time of service
  - 5) You have other insurance which must be filed first

Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as the patient to pay the denied amounts in full.

Our primary mission is to provide you with quality, cost effective, medical care. Together we are trying to adapt to the changing way that health care is financed and delivered. Again, we value you as a patient and our first priority is to provide you with the best possible care. With this housekeeping chore complete, we are pleased to serve you.

Sincerely,  
**Apex Surgical Care, P.A.**

\_\_\_\_\_ **Please note if you cancel surgery or do not show , you will be charged 100.00 dollars which will be your sole responsibility and are not refundable.**

I have completed this form with accurate information. I have read and understand my obligations and responsibilities. I acknowledge that I am fully responsible for supplying correct insurance information, billing information, and payment of any services not covered or approved by my insurance carrier.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date



Ricardo Lebron Valdez, M.D  
929 N. Galloway Ave. Suite 301 Mesquite, TX 75149

### Consent to Release Personal Health Information

Patient: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

List all family members or friends you give the staff at Apex Surgical Care, P.A. your authorization to release your personal health information to:

_____	_____
FULL NAME	RELATIONSHIP TO PATIENT
_____	_____
FULL NAME	RELATIONSHIP TO PATIENT
_____	_____
FULL NAME	RELATIONSHIP TO PATIENT
_____	_____
FULL NAME	RELATIONSHIP TO PATIENT

Do you authorize staff members of Apex Surgical Care, P.A. to leave messages on your voicemail or answering machine regarding results or appointments?

Circle one: YES NO

Do you authorize staff members of Apex Surgical Care, P.A. to e-mail your personal information to the e-mail address you provide?

Circle one: YES NO

If yes, please provide address: \_\_\_\_\_@\_\_\_\_\_

This authorization shall expire upon this expiration date: \_\_\_\_\_

\*\* This Authorization will not expire unless I list a date of expiration or written notification is received.

- I understand I have the right to revoke this authorization at any time. I understand I must do so in writing and present the written revocation to Apex Surgical Care, P.A. staff member.
- I understand the revocation will not apply to information that has already been released.
- The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Legal Representative \_\_\_\_\_ Date \_\_\_\_\_

If signed by legal representative, relationship to patient: \_\_\_\_\_

