

**DALLAS SURGICAL GROUP --- NEW PATIENT FORMS  
DEMOGRAPHICS INFORMATION**

PATIENT NAME: LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_ AGE \_\_\_\_\_ SEX F \_\_\_\_\_ M \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ EMAIL: \_\_\_\_\_

HOME PHONE # \_\_\_\_\_ CELL PHONE # \_\_\_\_\_

YOUR EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

WORK PHONE # \_\_\_\_\_

NAME OF SPOUSE/SIGNIFICANT OTHER: \_\_\_\_\_ DOB \_\_\_\_\_ CONTACT # \_\_\_\_\_

REFERRING PHYSICIAN \_\_\_\_\_ PRIMARY CARE DOCTOR \_\_\_\_\_

OB/GYN \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS OF CONTACT \_\_\_\_\_ BEST PHONE # \_\_\_\_\_

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**I GIVE PERMISSION TO ALLOW DALLAS SURGICAL GROUP TO LEAVE MESSAGES REGARDING MY MEDICAL CARE WHICH MAY INCLUDE PATHOLOGY AND RADIOLOGY RESULTS ON MY:**

\_\_\_ Home Answering Machine \_\_\_ Cell Phone \_\_\_ Work Voicemail \_\_\_ Email \_\_\_ Other ( \_\_\_\_\_ )

**I DO NOT GIVE PERMISSION TO ALLOW DALLAS SURGICAL GROUP TO LEAVE MESSAGES REGARDING MY MEDICAL CARE WHICH MAY INCLUDE PATHOLOGY AND RADIOLOGY RESULTS ON MY:**

\_\_\_ Home Answering Machine \_\_\_ Cell Phone \_\_\_ Work Voicemail \_\_\_ Email \_\_\_ Other ( \_\_\_\_\_ )

HEALTH INSURANCE NAME \_\_\_\_\_ INSURED'S NAME \_\_\_\_\_

ID # \_\_\_\_\_ GROUP # \_\_\_\_\_ INSURER DOB \_\_\_/\_\_\_/\_\_\_

DO YOU HAVE SECONDARY INSURANCE? \_\_\_ YES \_\_\_ NO

HEALTH INSURANCE NAME \_\_\_\_\_ INSURED'S NAME \_\_\_\_\_

ID # \_\_\_\_\_ GROUP # \_\_\_\_\_ INSURER DOB \_\_\_/\_\_\_/\_\_\_

***ASSIGNMENT OF BENEFITS***

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE COMPANY BENEFITS BE MADE ON MY BEHALF TO DALLAS SURGICAL GROUP FOR ANY MEDICAL SERVICES FURNISHED TO ME BY DALLAS SURGICAL GROUP. REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS APPLY.

***RELEASE OF MEDICAL RECORDS***

I AUTHORIZE DALLAS SURGICAL GROUP TO RELEASE ANY AND ALL MEDICAL INFORMATION ABOUT ME TO MY INSURANCE COMPANY OR THIRD PARTY ADMINISTRATOR, FOR THE ADJUDICATION AND PAYMENT OF MY MEDICAL CLAIMS.

***FINANCIAL RESPONSIBILITY***

I UNDERSTAND THAT ALL PROFESSIONAL SERVICES RENDERED ARE MY ULTIMATE RESPONSIBILITY EVEN IF A THIRD-PARTY ARRANGEMENT HAS BEEN MADE WITH DALLAS SURGICAL GROUP.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

# LETTERS FOR DOCTORS

**Patient's Name** \_\_\_\_\_

**Date** \_\_\_\_\_

Please list all the physicians that you would like us to send letters to regarding your visit with Dr. Beitsch.

Doctor Name

Phone Number

Address

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

4) \_\_\_\_\_

5) \_\_\_\_\_

# DALLAS SURGICAL GROUP

## Medical Records Release Form

This authorizes \_\_\_\_\_ to provide a copy, summary, or narrative of my medical records (as indicated by the checkmarks) or authorizes release of any pertinent confidential information.

- Complete medical records
- Records of care from the following dates: \_\_\_\_\_ to \_\_\_\_\_
- Records concerning the following condition(s): \_\_\_\_\_
- Other: \_\_\_\_\_
- Confer orally with the person listed below about my medical record.

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

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

Social Security #: \_\_\_\_\_

Please release to the following person:

Dr. Peter D. Beitsch  
7777 Forest Lane  
Suite C-760  
Dallas, Texas 75230  
Phone: (972) 566-8039  
Fax: (972) 566-8026

Patient Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**DALLAS SURGICAL GROUP**  
**Patient Consent and Acknowledgement of Receipt of Privacy Notice**

I understand that as part of the provision of healthcare services, Dallas Surgical Group creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notices and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations with out my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations, be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information which have been previously agreed upon.

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Patient's Name Printed

Date

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Patient's Signature (or guardian if a minor)

SS#

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Witness (Optional)

Date