

Patient Registration for Dr. William F. Tucker, Jr.

(Please print)

Name: _____

Address: _____

City/State/Zip: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

Social Security Number: _____ Date of Birth: _____ Age: _____ Sex: _____

Employer: _____ Employer's Telephone: _____

Employer's Address: _____

Occupation: _____

Emergency Contact: _____ Telephone: _____

Relationship to Patient: _____

Pharmacy: _____ Telephone: _____

Who referred you to our office? _____

We will need copies of your Driver's License/Photo ID and insurance cards at the time of service.

Payment is expected at the time of service. Payments should be made payable to William F. Tucker, Jr., M.D., P.A.

I understand that I am responsible for payment of all charges incurred on my behalf and/or family members, regardless of insurance benefits.

Signature: _____ **Date:** _____

Patient Name:

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I authorize William F. Tucker, Jr., M.D., P.A., to furnish requested information from the patient's medical and other records to 1.) any insurance company or third party payor for the purpose of obtaining payment on the account of William F. Tucker, Jr., M.D., P.A., 2.) any other person(s) or entities financially responsible for the patient's care or treatment, and 3.) representatives of local, state or federal agencies in accordance with law. Such information may include, but is not limited to, information concerning communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS"). I authorize the release of information from or the review of the patient's records for the purpose of conducting any medical audit, utilization reviews or quality assurance reviews. I authorize William F. Tucker, Jr., M.D., P.A., to release information from or copies of the patient's medical record to any referring physician or to any skilled nursing facility or other health care facility to which the patient may be transferred. Any other release of information requires my signed written permission.

Signature: _____

Date: _____

Signature of Spouse or Guardian:

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of services rendered, I hereby transfer and assign to William F. Tucker, Jr., M.D., P.A., all right, title and interest in any payment due me for services as provided in any policy or policies of insurance. I understand that I am responsible for providing to William F. Tucker, Jr., M.D., P.A., all insurance information at the time of my service, admission or during my hospital stay to allow for verification prior to my discharge, and that regardless of my assigned insurance benefits, I am responsible for the total charges for the services rendered.

Signed: _____

Date: _____

Signature of Spouse or Guardian:

William F. Tucker, Jr., MD, PA
8210 Walnut Hill Lane
Suite 404
Dallas, Texas 75231
214-265-5050 (Office) 214-265-0505 (Fax)

Consent for Treatment

I, knowing that I am suffering from a condition requiring diagnostic, medical or surgical treatment, do hereby voluntarily consent to such procedures and care and to such medical, surgical or other services under the general and specific instructions of Dr. William F. Tucker, Jr., his assistants or his designee as is necessary in his judgment.

I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatments or examination by Dr. William F. Tucker, Jr..

Patient Signature: _____
Date: _____

If patient is a minor or unable to sign:

Signature: _____
Relationship to Patient: _____
Date: _____

Health History

Patient Name:

Reason for today's visit:

Please circle "No" or "Yes" and provide any pertinent information.

No Yes Are you allergic to any medications? (If yes, what medication(s) and what reaction do you have)

No Yes Do you smoke? (If yes, what and how much)

No Yes Do you drink alcohol? (If yes, how much and how often)

No Yes Do you use (or have you ever used) any addictive or illegal drugs? (If yes, what and when)

Have you ever had: (If yes, please explain)

No Yes Arthritis: _____

No Yes Pneumonia: _____

No Yes Bronchitis: _____

No Yes Asthma: _____

No Yes Tuberculosis: _____

No Yes Emphysema/Shortness of Breath: _____

No Yes Other lung problems: _____

No Yes High Blood Pressure: _____

No Yes Chest Pain/Heart Attack: _____

No Yes Irregular Heart Beat/ Heart Murmur: _____

No Yes Other heart problems: _____

No Yes Do you have a Pacemaker or Defibrillator? _____

No Yes Anemia/Bleeding Problems: _____

No Yes Sickle Cell Disease/Trait: _____

No Yes Ulcers: _____

No Yes Hepatitis/Other liver problems: _____

No Yes Epilepsy/Seizures: _____

No Yes Stroke/Paralysis/Polio/Meningitis: _____

No Yes Kidney problems: _____

No Yes Diabetes: _____
No Yes Thyroid problems: _____
No Yes Back Pain or Injury/ Sciatica: _____
No Yes Any problems with Anesthesia? _____
No Yes Any loose teeth/ dentures? _____
No Yes Could you be pregnant? _____
No Yes Have you ever had a blood transfusion? _____
No Yes Are there any other medical problems that you feel we need to know about?

Patient Signature: _____

Date: _____

Past Surgical and Family History

Patient Name:

Please list any surgeries you have had and when:

Please list any significant illnesses that run in you family:

Current Medications

Please list all medications and/or dietary supplements you take (or you may provide a separate written or typed list):

Patient Signature: _____

Date: _____