Dr. William Carpenter
3409 Worth Street, Suite 630
Dallas, TX 75246
Phone: (214) 827-8407
www.drwilliamcarpenter.com

PATIENT REGISTRATION FORM

(Please Print)

Date _____ Drivers Lic.#_____ Sex: M___ F___ Referred By_____

Last Name _____First_____Middle_____

Preferred Name_____ Birthdate_____Age_____

Address _____ City_____State_____Zip_____

Home Phone _____Bus. Phone _____Cell _____

Employer _____ Occupation_____

Address _____ City_____State_____Zip_____

Spouse/Parent's Name _____ Occupation _____

Employer _____ Bus. Phone _____Cell_____

Address _____ City_____State_____Zip_____

Patient's SS# _____Spouse/Insured's SS# _____

Notify in case of emergency: Name _____Relationship _____

Home Phone _____Bus. Phone _____Cell _____

Primary Care Physician _____Phone_____

Nature of Visit_____

Primary Insurance _____ Insured's Name _____

ID# _____ Grp# _____ Employer _____

Secondary Insurance _____ Insured's Name _____

ID# _____ Grp# _____ Employer _____

TREATMENT AUTHORIZATION: The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform **Dr. William M. Carpenter** and/or his staff of any changes in my medical condition. I authorize **Dr. William M. Carpenter** and his staff to perform the necessary medical treatment.

_____ _____

Patient / Guardian Signature **Date**

MEDICAL HISTORY

(Please Print)

Name _____ **Date** _____

Please list any health problems_____

_____

Please list any medications you are taking (prescription and over the counter)_____

_____

_____

Are you allergic to any medications? _____

_____

Please list any previous surgeries _____

_____

Are you pregnant?_____

Do you smoke? _____ **If you have ever smoked, when did you stop?**_____

Have you or anyone in your family ever had problems with a general anesthetic? If so, what occurred?_____

_____

Do you now have or have you ever had: (please check all that apply**)**

- □ **Heart Disease**
- □ **High Blood Pressure**
- □ **Lung Problems**
- □ **Bleeding Disorder**
- □ **Intestinal Disease**
- □ **Diabetes**
- □ **Cancer**
- □ **Arthritis**
- □ **Stroke**
- □ **Epilepsy**

William M. Carpenter, MD
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Main 214 827-8407
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www.drwilliamcarpenter.com

FINANCIAL POLICY

We sincerely thank you for choosing our office for your healthcare needs. Please understand that payment of your bill is considered part of your treatment. Filing your insurance is a service provided to you free of charge, but in no way relieves you of the responsibility of your bill, (i.e. deductible, usual and customary rates and services not covered by your plan). The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment.

INSURANCE COVERAGE: Insurance is designed to reduce your costs, but usually will not eliminate them entirely. You are fully responsible for all fees charged by this office regardless of your insurance coverage. We will make every effort to fully inform you of all fees due and your insurance payment status. We try our best to verify your insurance coverage before you receive treatment; however, this is not always the case. This office does not accept total responsibility for verifying your insurance of for collecting your insurance claim. Ultimately the responsibility is the policyholders.

Thank you very much. We look forward to serving you.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AND ALL CHARGES INCURRED BY ME IN THIS OFFICE EXCEPT FOR CHARGES REQUIRED TO BE WRITTEN OFF BY CONTRACTUAL AGREEMENT. I HAVE READ, UNDERSTAND, AND AGREE TO THE PROVISIONS OF THIS FINANCIAL POLICY.

_____ _____
Signature Date

PAYMENT OF BENEFITS: I hereby authorize payment of benefits to **William M. Carpenter, MD** for services performed. I understand that I am financially responsible for charges not covered by this assignment.

_____ _____
Signature Date

PATIENT AUTHORIZATION: I authorize the release of any medical information necessary to process this claim. This information will be used for the purpose of evaluating and administering claims for benefits. I agree that a photographic copy of this authorization is as valid as the original.

_____ _____
Signature Date

CARPENTER & MORALES, MD,PA

Plastic and Reconstructive Surgeons

ACKNOWLEDGEMENT OF REVIEW OF
NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Print Name of Patient of Personal Representative