Patient Registration

Account No. (Office Use Only)

Referred By	Date

How did you hear about us?

Would you like to be added to our mailing list? ☐ Yes ☐ No Thanks

Patient

Full Name				
Social Security No.	D.O.B.	Age	☐ Male ☐ Female	
Home Phone	Work Phone	Fax Phone		
Cell Phone	Preferred Phone	Pharmacy Phone		
Email Address		Drivers License No.		
Mailing Address				
City, State, Zip				

Employment (if minor, responsible parties)

Employed By	
Position	May we call you at work? ☐ Yes ☐ No
Address	

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name	Social Security No.
Spouse's Employer	Phone No.
Address	

In Case of Emergency

Name	Relationship	Phone No.
Name	Relationship	Phone No.

I understand that I am financially responsible for all charges. Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, money orders and most major credit cards.

Signature ______________________________ Date ____________

Health History Form

Name	Date
Address	

D.O.B.	Age	Weight	Height	Cell Phone
Reason for visit today?				Other Phone

Past/Current Hx (Check all that apply)

- ☐ Lung Disease
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Keloids
- ☐ Abnormal/ Excessive Bleeding
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Hepatitis
- ☐ MRSA/Staph
- ☐ Taken Accutane within Past Year
- ☐ Kidney Disease
- ☐ Chest Pain
- ☐ HIV
- ☐ Fever Blisters
- ☐ Neck Problems
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Seizures
- ☐ Dry Eyes
- ☐ Sleep Apnea
- ☐ Latex Allergy
- ☐ Use CPAP/BPAP

Other Major Illnesses:

Medications: Name	Reason for Taking	Frequency/Dose

Do you take ANY Diet Pills, Natural Herbs or Health Food Supplements? If Yes, What: ____________

Any Allergies and/or Reactions to Medication? ____________

Any Previous Surgeries? ____________

Have you or anyone in your family had complications from anesthesia? If Yes, please explain:

Have you had any blood clots? If Yes, please explain: ____________

Have you been on ANY steroids in the last year? If Yes, please explain: ____________

Do you take asprin on a regular basis? ☐ No ☐ Yes

Do you have excessive bleeding or bruising: ☐ No ☐ Yes

Do you use any Tobacco products? ☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes

Do you have any teeth that are: ☐ Loose ☐ Fragile ☐ Capped ☐ False

Signature	Date:

Fritz E. Barton, Jr., M.D., P.A.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Protecting your privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. At Dr. Barton's (hereafter referred to as "the Practice"), privacy is one of our highest priorities.

Keeping your information

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

Working to meet your needs through information

In the course of doing business, we collect and use various types of information, like name and address and claims information. We use this information to provide service to you, to process your claims and to bring you health information that might be of interest to you.

Keeping information accurate

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please call or write us at the telephone number or address listed below.

We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How - and why – information is shared

We limit who receives information and what type of information is shared.

Sharing information within the Practice. We share information within our office to deliver you the health care services and the related information and education programs in your plan.

Sharing information with companies that work with us. To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies that deliver health education and information directly to you. These companies act on our behalf and are obligated to keep the information that we provide them confidential.

Other. Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.

If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies.

The Practice does not share any customer information with third-party marketers who offer their products and services to our patients.

Count on our commitment to your privacy

You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us-whether it's at our office, over the phone or through the Internet.

Fritz E. Barton, Jr., M.D., P.A.
4311 Oak Lawn Avenue, Suite 380
Dallas, TX 75219
214-821-9355

Fritz E. Barton, Jr., M.D., P.A.

Patient Consent and Acknowledgment of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Dr. Barton 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 Notice 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 request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care 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 require 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 been made in reliance 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 health care operations without 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 on the use an disclosure of my Protected Health Information that I request in writing, and, when I request in writing, agree to terminate any restrictions on the use and disclosure of my Protected Health Information which have been previously agreed upon.

______________________________	______________________________
PATIENT'S NAME PRINTED	DATE
PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR)	DATE OF BIRTH
WITNESS (OPTIONAL	DATE

PHOTOGRAPH CONSENT FORM

I, the undersigned, hereby authorize Dr. Fritz E. Barton to take my pre-photos for planning purposes, medical evaluation, surgical or other procedures and subsequent treatment. **Your photos will not be used in any publication or on the internet without your notification and a separate form signed by you**

PERSON PHOTOGRAPHED

Please PRINT your name:______________________________________

SIGNATURE:___________________________ Date:______________

WITNESS (print):____

SIGNATURE:___________________________ Date:______________

Requested by Fritz E. Barton, Jr., M.D.
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