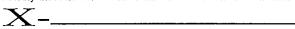
)	Noel Lopez, M.D. 5140 N. 10th St McAllen, TX 78504 Phone: (956) 972-1600 - Fax: (956) 972-0880

	Patient I	nformation				
Name: (First, Middle, Last)		Date of Birth;				
Address:						
	Sex: M	<u> </u>				
		Vork Phone: E-mail				
Maiden Name:		s: Employed Part-time Student Full-time Student Other				
	Employme	nt Information				
Employer:	Occupation:					
Address:		(City, State, Zip):				
		arty Information				
Name:		Date of Birth:				
		(City, State, Zip):				
Social Security #:	Responsible Party's Phone #-	Relationship to Patient:				
	Employer:	Employer Phone:				
		Information				
Name of Insured:	-	Relationship to Patient:				
		Phone:				
	Group #-	ID Number:				
Address:		(City, State, Zip):				
	Spouse I	nformation				
Name: (First, Middle, Last)		Date of Birth:				
Address:		(City, State, Zip);				
Social Security #:	Employer:	Employer Phone:				
	Relative to Contact	in Case of Emergency				
Name:	Phone:	Relationship to Patient:				
Address:		(City, State, Zip):				
	Is Your Illness or Injury	Related to Any of the Following?				
Employment Emergency	Accident Auto Accident (State of Auto Ac	cident)				
if Employment related, has empl	oyer been notified?	Employer Contact Name:				
Employer Contact Phone and Ext	ension:					
	How Were You Re	eferred to Our Office				
☐ By an Attorney ☐ By a Docto	or By a Patient Yellow Pages Other					
Please print the name of your sou	ırce:					
	Consent to Treatment / Financial Res	ponsibility and Assignment of Benefits				
I voluntarily consent to receive m	edical and health care services that may include	diagnostic procedures, examination, and treatment.				
		and interest to my medical reimbursement benefits under my insurance esse benefits. This authorization shall remain valid until written notice is				

given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I certify that I have read this form and understand its contents.



Date:				Liet	the Main	reason	n(s) for your visit v	with the doctor:
Name:					,		•	
Date of Birth:				1)_				
SS#: -				2)_		<u></u>		
Account #:				ے(د 				
(Details of your								
Have you had a Fatigue Generalized weak		ollowing re Eye paln Loss of visi		Sore t	hroat sive thirst		Chest pain Palpitations Breast pain	Bloody stools Black stools
Weight loss(exces	sive)	Double vision	on		sores		Swollen ankles	Constipation Hemorrhoids
Weight gain(exces	sive)	Spots in the Ear pain- rig		Hoars Neck			Breast lump	Rectal pain
Fever Chills		Hearing los		Neck			Breast discharge Nausea	Hernia Painful urination
Night sweats		Ear drainag	e		n with phle	gm	Vomiting	Frequent urination
Headaches-Tensi	on/Migraine	Ear pressu	e	Dry co	ough ning up blo	od	Abdominal pain	Blood in urine
Insomnia	,	Ringing in the Nasal cong		Short	ness of bre	ath	Abdominal bloating	
Sleeping too much Depression	i	Nose bleed			o breath	,	Diarrhea	Genital discharge Back pain
Crying spells		Sinus pain						Extremity pain
Social History:	(circle)					Subst	ance History: (dir	cle)
						Have	you ever smoked	: Yes No
Occupation:					Do		much?	Year Quit
							u drink alcohol?	
Do you live ald	one?: Ye	s No				How	much?i	ed drugs? Yes No
	umuhudubu					1		į
List your drug a	allergies:					Lis —	st)	
List all your sur	rgeries:							
Have you had	any of the	following?	(circle)					
Allergies	Diabetes		Kidney	stones		eding di		
Asthma	High blood		Kidney			roid disc oritis	TIA	лна
Emphysema	High chole Heart attac		Dialysis	s ransfusio		lepsy	Cancer	
Tuberculosis Angina	Stroke	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Hepatit		Alc	oholism		attempt
Gout	Depression	1	Ulcers		Dru	ig abuse		
Other illnesses:		Incope =:	n in vous	family	' (alsala)		How long(yrs) s	ince vour lact:
Do any of the	_	iiiesses Tu				200000		-
Astnma Emphysema					sorder Prostate cancer order Breast cancer		Physical exam	_ MALES: PSA test
Tuberculosis	High chol		Arthritis		Lung can		Flu vaccine Rectal exam	FEMALES: Last period
Gout	Heart atta	ck	Epilepsy		Colon ca		Tetanus booster_	Mammogram
Kidney stones Ulcers	Stroke Depression	าก	Alcoholisr Drug abus		Suicide a	ittempt	Chest X-ray	PAP smear
	•							
List all your m	nedications	·					<u></u>	

.

Insurance is a way for you to receive repayment for fees you have paid to a physician for services rendered. Having insurance is not a substitute for payment. Even though insurance companies have a fixed allowance or percentage based on your policy with them, your policy is with your insurance company, not with this office. It is your responsibility to provide payment for the deductible, co-insurance, and any other balances not paid for by your insurance. We will assist you in receiving reimbursement in any way possible, but you are ultimately responsible for the payment of your bill.

Primary Insurance;	Effective Date:
Address:	
Policy #: Group #:	Phone #:
Insured:	Relationship to Insured:
and the second s	The second secon
Secondary Company:	Effective Date:
Address:	City/State/Zip:
Policy #: Group #:	
insured:	Relationship to Insured:
insurance claim. This agreement will remain in efficiency be considered as valid as the original. Non-Medicare Patients I authorize the release of all medical records need assign all medical and/or surgical benefits, including	test any information necessary to determine benefits and process the fect until revoked by me in writing. A photocopy of this agreement is to led to process this claim and that is pertinent to my medical care. I mg major medical benefits to which I am entitled, to Noel Lopez, M.D I by me in writing. A photocopy of this assignment is to be considered
I ASSUME FINANCIAL RESPONSIBILITY FO	OR ALL CHARGES. I HAVE READ THE ABOVE INFORMATION
Patient:	
(If patient is a minor, a parent's signature is required)	(responsible party)
(witness)	(date)

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 the document.						
gnature of Patient or Personal Representative						
ale						
·						
ame of Patient or Personal Representative						
scription of Personal Representative's Authority						