

Date: \_\_\_\_\_

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

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

Account #: \_\_\_\_\_

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

List and describe the reason for your visit:
Problem #1:
Problem #2:
Problem #3:

**Social History:**

Marital Status:  Single  Married  Widowed  Common Law

Occupation: \_\_\_\_\_

How many children do you have? \_\_\_\_\_

Do you live alone?:  Yes  No

List your drug **allergies**: \_\_\_\_\_

List all your **surgeries**: \_\_\_\_\_  
\_\_\_\_\_

Have you ever smoked? If so, how much? \_\_\_\_\_ Year quit? \_\_\_\_\_

Do you drink alcohol? If so, what type and how much? \_\_\_\_\_

Do you use illicit drugs? If so, please list? \_\_\_\_\_

**Have you had any of the following?** (circle)

- |              |                     |                   |                   |                 |
|--------------|---------------------|-------------------|-------------------|-----------------|
| Allergies    | Diabetes            | Kidney stones     | Bleeding disorder | Glaucoma        |
| Asthma       | High blood pressure | Kidney failure    | Thyroid disorder  | Pneumonia       |
| Emphysema    | High cholesterol    | Dialysis          | Arthritis         | TIA             |
| Tuberculosis | Heart attack        | Blood transfusion | Epilepsy          | Cancer of _____ |
| Angina       | Stroke              | Hepatitis         | Alcoholism        | Suicide attempt |
| Gout         | Depression          | Ulcers            | Drug abuse        |                 |
- Other illnesses: \_\_\_\_\_

**Do any of the following illnesses run in your family?** (circle)

- |               |                     |                   |                 |
|---------------|---------------------|-------------------|-----------------|
| Asthma        | Diabetes            | Bleeding disorder | Prostate cancer |
| Emphysema     | High blood pressure | Thyroid disorder  | Breast cancer   |
| Tuberculosis  | High cholesterol    | Arthritis         | Lung cancer     |
| Gout          | Heart attack        | Epilepsy          | Colon cancer    |
| Kidney stones | Stroke              | Alcoholism        | Suicide attempt |
| Ulcers        | Depression          | Drug abuse        |                 |

List all your medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Noel Lopez, M.D.**

5140 N. 10th Street - McAllen, TX 785042834

Phone: (956) 972-1600 - Fax: (956) 972-0880

**Patient Information**

Name: (First, Middle, Last) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ (City, State, Zip): \_\_\_\_\_

Social Security#: \_\_\_\_\_ Sex:  M  F Marital Status:  Single  Married  Widowed  Divorced

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile Carrier: \_\_\_\_\_

Maiden Name: \_\_\_\_\_ Employment Status:  Employed  Part-time Student  Full-time Student  Other

**Employment-Information**

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ (City, State, Zip): \_\_\_\_\_

**Responsible Party Information**

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

Address: \_\_\_\_\_ (City, State, Zip): \_\_\_\_\_

Social Security#: \_\_\_\_\_ Responsible Party's Phone#: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

**Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ Social Security #- \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group #- \_\_\_\_\_ ID Number: \_\_\_\_\_

Address: \_\_\_\_\_ (City, State, Zip): \_\_\_\_\_

**Spouse information**

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 Accident) \_\_\_\_\_

If Employment related, has employer been notified?  Yes  No Employer Contact Name: \_\_\_\_\_

Employer Contact Phone Extension: \_\_\_\_\_

**How were you referred to our office?**

By an Attorney  By a Doctor  By a Patient  Yellow Pages  Other

Please print the name of your \_\_\_\_\_

**Consent to Treatment/Financial Responsibility and Assignment of Benefits**

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination, and treatment.

I hereby assign, transfer, and set over to Noel Lopez, M.D. all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these 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.**

Patient or Other Legally Authorized Person: \_\_\_\_\_ Date: \_\_\_\_\_



Noel Lopez, M.D.

5140 N. 10Th St - McAllen, TX 78504

Phone: (956) 972-1600 - Fax: (956) 972-0880

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: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Phone # \_\_\_\_\_  
 insured: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

**Secondary Company:** \_\_\_\_\_ Effective Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group #\* \_\_\_\_\_ Phone #\* \_\_\_\_\_  
 insured: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

**Medicare Patients**

I request that payment of authorized Medicare benefits be made to me or on my behalf to Noel Lopez, M.D. for any services furnished me by Noel Lopez M.D. I authorize that any holder of medical records about me to release to the Health Care Financing Administration and its agents any information necessary to determine benefits and process the insurance claim. This agreement will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

**Non-Medicare Patients**

I authorize the release of all medical records needed to process this claim and that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, to Noel Lopez, M.D. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I ASSUME FINANCIAL RESPONSIBILITY FOR ALL CHARGES. I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND IT.

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 this document.

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Signature of Patient or Personal Representative

---

Date

---

Name of Patient or Personal Representative

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Description of Personal Representative's Authority

# Internet Communication Consent

In an effort to provide better care for our patients, we are introducing an E-MAIL communication option for you. There are two e-mail addresses to choose from.

[nurse@lopezpvmc.com](mailto:nurse@lopezpvmc.com)      [clerk@lopezpvmc.com](mailto:clerk@lopezpvmc.com)

Use the nurse e-mail to:

- Request medication refills. (Please allow 72 hours for refills)
- Request follow-up appointments for lab & other tests

Use the clerk e-mail to:

- Prior-Authorizations from Insurance companies.
- All billing & insurance questions.
- Request appointments

Be sure to include patients Name: \_\_\_\_\_ DOB: \_\_\_\_\_

(Your name and relationship if you are not the patient)

Complete message including preferred pharmacy if refills.

If you want an appointment, please specify morning or afternoon preferred day and nature of visit. (Annual physical, follow-up for lab & outside tests, I need insurance forms filled out, etc..)

**If you have an URGENT NEED, please call our main-line at (956) 972-1600.**

Please sign the E-mail Consent below if you wish to communicate by email with this office.

You must initiate the E-mail communication in order for us to send you the information you need. Response will only be to email accounts on file with this office. If you change your email account or wish to no longer use this service, you must notify us in writing of the changes and effective date. A separate form must be signed for every family member.

I, \_\_\_\_\_, consent to E-mail communication to the e-mail on file.  
(PRINT NAME)

EMAIL: \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE