

**Diagnostic Medical Associates of North Texas**  
Jennifer Attmore, M.D., P.A. - Agnes Kinra, M.D., P.A.  
Michelle Sun, M.D., P.A - Catheryne Zavodny, M.D., P.A.

**Patient Registration**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth date: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

SSN: \_\_\_\_\_ Medicare #: \_\_\_\_\_

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

Bus. Address: \_\_\_\_\_ City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ State: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Referred by: \_\_\_\_\_

**Insurance Information**

Insured's name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Insured's employer: \_\_\_\_\_ Insurance carrier: \_\_\_\_\_

Group #: \_\_\_\_\_ ID#: \_\_\_\_\_ PPO? YES \_\_\_ NO \_\_\_

Insurance company address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Secondary Insurance Information – If None, Check Here: \_\_\_\_\_**

Insured's name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Insured's employer: \_\_\_\_\_ Insurance carrier: \_\_\_\_\_

Group #: \_\_\_\_\_ ID#: \_\_\_\_\_ PPO? YES \_\_\_ NO \_\_\_

Insurance company address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Emergency Contact Information**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

## New Patient Medical History

Patient's name: \_\_\_\_\_ Date of visit: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_

*Use a separate sheet of paper if you need more space*

- **Medical History**—List all medical conditions you have had (including high blood pressure, diabetes, thyroid disease, heart disease, blood transfusions, etc.) and the dates of diagnosis:

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- **Surgical History**—List all operations you have had and the dates of the surgeries:

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- **Other physicians / specialists you see**

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- **Ob/Gyn History**—This section for women only

Age at first menstrual period: \_\_\_\_\_ Date of 1<sup>st</sup> day of last period: \_\_\_\_\_

Number of pregnancies: \_\_\_\_\_ Live births: \_\_\_\_\_ Stillborn: \_\_\_\_\_

Miscarriage: \_\_\_\_\_ Abortion: \_\_\_\_\_

Have you had a hysterectomy? \_\_\_\_\_ If so, when? \_\_\_\_\_ Ovaries removed? \_\_\_\_\_

- **Health Maintenance**—Level of Activity/Exercise: \_\_\_\_\_

Dates of last test—Blood in stool: \_\_\_\_\_ Colonoscopy: \_\_\_\_\_ EKG: \_\_\_\_\_

Tetanus vaccine: \_\_\_\_\_ Flu shot: \_\_\_\_\_ Pneumonia vaccine: \_\_\_\_\_

(Men only – PSA Test: \_\_\_\_\_) (Women only: pap smear: \_\_\_\_\_)

Breast exam: \_\_\_\_\_ mammogram: \_\_\_\_\_ bone density: \_\_\_\_\_)

- **Medications**—List all medications you take on a regular basis, including over-the-counter medicines, vitamins, and herbal supplements:

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- **Allergies**—to medications or foods and reaction: \_\_\_\_\_

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- **Social History**—Marital status: \_\_\_\_\_ Occupation: \_\_\_\_\_

Alcohol: (how much, how often?) \_\_\_\_\_

Tobacco: (how much, how often?) \_\_\_\_\_

Illicit drug use: \_\_\_\_\_

- **Family History**—Please include any history of medical or psychiatric condition in your blood relatives including heart disease, stroke, diabetes, cancer, osteoporosis, depression, etc.

<u>Relative</u>	<u>Age (current/at death)</u>	<u>Medical Illnesses</u>
<u>Mother</u>	_____	_____
<u>Father</u>	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## Review of Systems

Please note whether you have had the following systems recently.

Symptom	Y/N	Comments
Fatigue		
Weight loss or gain		
Insomnia		
Change in appetite		
Depression		
Anxiety		
Skin rash or lesions		
Headaches		
Dizziness		
Vision changes		
Hearing loss		
ringing in your ears		
Mouth sores		
Shortness of breath		
Cough/coughing up blood		
Wheezing		
Chest pain		
Awakening short of breath		
Heart palpitations/fluttering		
Swelling in your legs		
Trouble swallowing		
Nausea/vomiting		
Blood in stool		
Black, tarry stools		
Diarrhea		
Constipation		
Trouble initiating urination		
Trouble stopping urination (dribbling)		
Urinating too frequently		
Urinating at night (>2 times)		
Blood in urine		
Incontinence		
Impotence/decreased libido		
Excessive hunger or thirst		
Sensitivity to hot or cold		
Nosebleeds		
Bruising easily		
Enlarged lymph nodes		

## **Payment Policy**

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## **Internal Medicine**

3900 West 15<sup>th</sup> Street, Suite 404  
Plano, TX 75075  
972-596-1803

We hope to provide you with quality and affordable care for your internal medicine needs. We hope that this payment policy will answer your questions regarding patient and insurance responsibilities for services rendered in this office.

**Method of payment:** Our practice accepts checks (however a charge will be assessed for those that are returned by the bank) and cash. **No credit, debit, or flex spending cards are accepted.**

**Insurance:** We participate in most insurance plans and Medicare. We do not accept Medicaid. If our practice is not contracted with your insurance plan, payment in full is expected at each visit. If you are insured by a plan with which we do business, but you do not have an up-to-date insurance card, you **MUST** have the insurance companies name, group number, type of plan (PPO, POS, HMO,) the claims address, and your co-payment amount, otherwise, payment in full for each visit is required until you can update your coverage. **Knowing and providing your insurance benefits is your responsibility.** Please contact your insurance company with any questions you may have regarding your coverage, including whether or not you have well or preventive coverage. Please allow your insurance carrier 45 days to process your claim.

**Co-payments and deductibles:** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Your insurance company considers it fraud if we fail to collect co-payments from its members. Please help us abide by the law in paying your co-payment at each visit.

**Non-covered services:** Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered necessary by Medicare or other insurance companies. You must pay for these services in full after your insurance company makes their determination. Due to the contract language between physician and insurance company, you must understand that you are financially responsible for all charges deemed to be “non-covered benefits” by your insurance even if the insurance’s Explanation of Benefits states that the procedure is a “non-covered benefit” and “patient is not responsible.”

**Proof of insurance:** All patients must complete our patient information before seeing the doctor. We must obtain a copy of your driver’s license and current valid insurance card to provide proof of insurance. The patient information and copy of valid insurance card may need to be completed again upon change of that information, but no less than every twelve months. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the full payment of a claim.

**Claims submission:** We will submit your primary claim and your secondary claims. Due to increasing administrative costs, we will not submit third and fourth insurance claims. We will assist you in any reasonable way we can help to get your claims paid, but your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract. Please understand that the balance of your claim is your responsibility whether or not your insurance pays your claim.

**Coverage changes:** If your insurance changes, please notify us before or at your next visit, so we can update your insurance information to help you receive maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you for prompt payment.

**Self-pay patients:** If you do not have insurance coverage, full payment is **expected** at the time of service. We offer a 20% discount to those patients who pay **IN FULL** at the time of service.

**Nonpayment:** If your account is over 90 days past due, you will be expected to pay the past due balance in 21 days. Partial payments will not be accepted unless approved by the office manager. Be aware that if the balance remains unpaid, we may refer your account to a collection agency and you may be discharged as a patient from this practice. If this is to occur, you will be notified by regular and/or certified mail that you have 30 days to find another physician. During that 30 day period, our physician will only be able to treat you on an emergency basis.

**Missed appointments:** Our practice reserves the right to charge \$25.00 for missed appointments not cancelled at least 24 hours in advance. These charges will be your responsibility and billed directly to you. Please help us to better serve you by being on time for your scheduled appointments.

**Thank you for reviewing our payment policy.** Please let us know if you have any questions or concerns. Our practice is committed to providing the best treatment for our patients. Our prices are representative of reasonable and customary charges for our area.

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Patient/Legal Guardian Signature

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Date

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Print Name