

Dorothy Cohen Serna, M.D., P.A.  
Kelly M. Englund, M.D.  
Internal Medicine  
[www.northcypressinternalmedicine.com](http://www.northcypressinternalmedicine.com)

21216 Northwest Fwy, #420  
Cypress, TX 77429  
Phone 281-807-5300  
Fax 281-807-5311

## **REGISTRATION INFORMATION**

(PLEASE PRINT)

Date \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Patient \_\_\_\_\_

Last Name

First Name

Initial

Street Address \_\_\_\_\_

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

Sex  M  F Age \_\_\_\_\_ Birth date \_\_\_\_\_ Social Security

#(Patient's) \_\_\_\_\_

Single  Married  Widowed  Separated  Divorced

Please note that we have been mandated to collect data on the following three questions:

Preferred Language English Other \_\_\_\_\_

Race  Caucasian  African American  Asian  Native American  Other  Decline to Answer

Ethnicity  Non-Hispanic  Hispanic  Other  Decline to Answer

Employed by Business Name \_\_\_\_\_  Full-Time Student  Part-Time

Student

Business Address \_\_\_\_\_

Occupation \_\_\_\_\_ Business phone \_\_\_\_\_

Spouse (or responsible party) Name \_\_\_\_\_ Birth date \_\_\_\_\_

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

Cell Phone Spouse (or responsible party) \_\_\_\_\_ Business phone \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Do you have Medical Insurance?  Yes  No

Name of Primary Insurer \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Who is the insured?  Self  Spouse  Parent Insured's Soc.Security#

\_\_\_\_\_  
Name of Secondary Insurer (if any) \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Dorothy Cohen Serna, M.D., P.A.  
Kelly M. Englund, M.D.  
Internal Medicine  
[www.northcypressinternalmedicine.com](http://www.northcypressinternalmedicine.com)

21216 Northwest Fwy, #420  
Cypress, TX 77429  
Phone 281-807-5300  
Fax 281-807-5311

Are you covered under any of these programs? Medicare Medicaid ChampVA Worker's Comp

Is your condition related to employment (current or previous)?  No  Yes

Is your condition related to auto accident?  No  Yes Other Accident?  No  Yes

**In case of emergency, who should be notified?**

Phone	Relationship to patient
-------	-------------------------

(OVER)

Please list other doctors you have seen in the past 5 years:

1. \_\_\_\_\_ City/State \_\_\_\_\_  
(General Practitioner, Specialist, or other)

2. \_\_\_\_\_ City/State \_\_\_\_\_  
(General Practitioner, Specialist, or other)

Reason for seeing \_\_\_\_\_

How did you learn of our practice? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I, the undersigned have insurance coverage with \_\_\_\_\_  
Name of insurance Company

And assign directly to **DOROTHY COHEN SERNA, M.D., P.A.** all medical benefits, if any, otherwise payable to me for services rendered. I understand that **I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. If my insurance changes in the future, with my signature here I am as well agreeing to all provisions herein to apply to my new insurance carrier.

I also acknowledge that insurance is only a method of payment and that my policy may contain certain limited and/or restricted guidelines for payments on various procedures which constitute 'their' reasonable and customary limits.

I agree to pay DOROTHY COHEN SERNA, MD, PA for any charges denied and/or remaining balance for professional services provided beyond the sums paid by my insurance carrier(s).

I understand that North Cypress Medical Center is a Physician Owned and Operated Hospital and that Dr. Serna has an ownership interest in the hospital.

I understand that if North Cypress Medical Center is out of network with my Insurance Plan, I will be eligible for a significant prompt pay discount by paying on a timely basis. I understand that if I have questions or concerns about this, I can confer with my Doctor or the North Cypress Medical Center Business Office prior to any services being rendered at that facility.

I also understand that my Doctor is an Attending Physician at hospitals that may be out of network with my Insurance Plan. I understand that I have the option to get my care at either an in-network or an out-of-network facility and that if I have any questions regarding this, I can ask my Doctor or the Business Office for more information.

Signature of Insured/Guardian

Date

**MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **DOROTHY COHEN SERNA, M.D., P.A.** for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and

Dorothy Cohen Serna, M.D., P.A.  
Kelly M. Englund, M.D.  
Internal Medicine  
[www.northcypressinternalmedicine.com](http://www.northcypressinternalmedicine.com)

21216 Northwest Fwy, #420  
Cypress, TX 77429  
Phone 281-807-5300  
Fax 281-807-5311

authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_  
Beneficiary Signature

\_\_\_\_\_  
Date