North Cypress Internal Medicine and Wellness
10425 Huffmeister Rd., Suite 460
Houston, TX 77065

Ph: 281-807-5300
Fax: 281-807-5311
https://drserna.com
https://doctorenglund.com

PATIENT INFORMATION

This information will be placed in your confidential medical record and will be used exclusively by the medical practice of North Cypress Internal Medicine and Wellness to facilitate care.

PLEASE PRINT -- THANK YOU!

Last Name **First Name** **M.I.**

Address **City, State, Zip**

Date of Birth **Age** ☐ **Female** ☐ **Male**

Employed by:_____ **Occupation:**_____

Home Phone # **Work Phone #** **Cell Phone #**

Patient E-mail Address **Pharmacy Name** **Pharmacy Phone #**

☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**

Name of Spouse/Partner (Full Name) (if applicable)

Please indicate your preferred contact phone # (circle one)	**Home**	**Work**	**Cell**
May we leave a detailed message at your preferred phone #?		**Yes**	**No**
May we release your medical information to your spouse/partner?		**Yes**	**No**
Are you active on the patient health portal?		**Yes**	**No**
Do you check your email on a regular basis?		**Yes**	**No**
Do you have dependent children signed up for the practice?		**Yes**	**No**

If yes, list name(s): _____

Who is responsible for this account? _____ Relationship to Patient_____

Please complete ALL information and return this document to our office.

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Do you have an immediate family member(s) who is highly involved in your care? Yes No

If yes, list name(s) and daytime phone: _____

_____

Do we have permission to contact them with medical information? Yes No

EMERGENCY CONTACT INFORMATION

_____ _____ _____
Last Name First Name Relationship

_____ _____
Home Phone # Other Phone #

OTHER PHYSICIANS SEEN

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 other physician/s _____

PLEASE TELL US:

How did you learn of our practice? _____

Whom may we thank for referring you? _____

_____/_____/_____
Patient's Name Signature Date

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INSURANCE INFORMATION

Do you have Medical Insurance? Yes No

Name of Primary Insurer: _____ ID # _____ Group # _____

Who is the insured? □Self □Spouse □Parent

Name of Secondary Insurer (if any) ID# _____ Group # _____

Are you covered by any of the following programs: (circle all that apply) Medicare Medicaid Workers Comp

ASSIGNMENT AND RELEASE
I, the undersigned have insurance coverage with the above company (s) 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 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 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 non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.
Beneficiary Signature Date

Please complete ALL information and return this document to our office.