Dr. Ted Kovacev M.D., P.A.

Patient Registration

Full Legal Name: _____ MI: _____

Mailing Address: _____

City: _____ State: TX ☐ , Other _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Age: _____ Date of Birth: _____ Sex: M☐ F☐

Social Security #: _____

Marital Status: Single ☐ Married ☐Divorced ☐ Widowed ☐ Other ☐ _____

Spouse's Name: _____

Do you consent to receive statements and appointments by email: Yes☐ No☐

Email Address: _____

Preferred Pharmacy: _____ Location: _____

Do you have a primary care doctor? Yes☐ No☐ Name: _____

Employment Information

Employment Status: Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Self-Employed ☐ Student ☐

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ Extension: _____

Payment Information

Do you have insurance? Yes ☐ No ☐ Are you a self-pay patient? Yes ☐ No ☐

How did you find Dr. Kovacev? _____

Person to notify in case of emergency: _____Relationship:_____

Phone: _____ Cell ☐ Home ☐ Other ☐

Primary Insurance Holder (if different from above)

Name : _____ Relationship to patient: _____

Social Security # _____ Date of Birth: _____

Mailing Address: _____ City: _____

State: _____ Zip:_____ Cell Phone: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name Ted Kovacev M.D. P.A.
Address 104 Circle Way, Suite A
City Lake Jackson State Texas Zip Code 77566
Phone (979)721-7007 Fax (979)721-4254

REASON FOR DISCLOSURE
(Choose only one option below)

- ☑ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☑ Billing or Claims
- ☑ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☑ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☑ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

New Patient History

Dr. Kovacev
Board Certified in General Surgery

Name : _____ Birthday: _____ Age _____

Ethnicity: _____ Primary Language: _____

Person Completing List: Self: ☐ Other: ☐ If Other Please Print Name: _____

Please Explain the Reason for Your Visit:

_____

Medical History: Place Check Mark in box ☑

High Blood Pressure	☐	Cancer	☐	Depression / Anxiety / Bipolar	☐	Gynecologic Disease	☐
Diabetes	☐	COPD / Asthma	☐	Visual Problems	☐	Skin Disorders	☐
CHF	☐	Circulatory Issues	☐	Neuropathy	☐	Hernias	☐
Stroke	☐	GERD / Reflux	☐	Clotting Disorder	☐	Sexual Dysfunction	☐
Heart Attack	☐	Ulcers	☐	Cirrhosis	☐	Incontinence	☐
Seizures	☐	Indigestion	☐	HIV / AIDS	☐	Hemorrhoids	☐
High Cholesterol	☐	Hepatitis	☐	Autoimmune Disease	☐	Breast Disease	☐
Arrhythmia	☐	Kidney Disease	☐	Prostate Issues	☐	Other : Write Below	☐

If not listed above please explain:

_____

Surgical History: Place Check Mark in box ☑

Cardiac	☐	Fatty Tumors	☐	Umbilical Hernia	☐	Amputation	☐
Chest	☐	Abscess	☐	Groin Hernia	☐	Colonoscopy	☐
Lung	☐	Reflux	☐	Other Hernia	☐	Upper Endoscopy	☐
Skin	☐	Rectum	☐	Eye Surgery	☐	Prostate	☐
Colon	☐	Hysterectomy	☐	Spinal Surgery	☐	Pacemaker / Defribrillator	☐
Liver	☐	Hemorrhoids	☐	Brain Surgery	☐	Heart Stents	☐
Gallbladder	☐	C-Section	☐	AV Fistula / Graft	☐	Transplant	☐
Appendix	☐	Tubal Ligation	☐	Breast Surgery or Biopsy	☐	Catheters / Ports	☐

If not listed above please explain:

_____

New Patient History

Dr. Kovacev
Board Certified in General Surgery

Name: _____ Birthday:_____

Screening History:

Test:		*Year*		*Findings*		*Doctor*	
Colonoscopy							
Breast Cancer							
Gynecologic Cancer							
Prostate Cancer							
Skin Cancer							

Pharmacy: (Name, Location, Phone)

_____

Allergies: (Drug or Food)

_____

_____

Medication List: (Include Vitamins, Daily Aspirin, ect.)

Name of Medicine	*Dose*	*How Often*	*How Long*	*Last Time Taken*

☑

Family History: Place Check Mark in box

Colon Cancer	☐	Liver Disease	☐	Prostate Cancer	☐	Polyps	☐
Rectal Cancer	☐	Lung Cancer	☐	Crohns Disease	☐	Stomach Cancer	☐
Heart Disease	☐	Gallbladder Disease	☐	Ulcerative Colitis	☐	Psychiatric Disorder	☐
Bleeding Disorders	☐	Appendectomy	☐	Breast Cancer	☐	Substance Abuse	☐
Skin Cancer	☐	Hernias	☐	Uterine / Ovarian Cancer	☐	Other: Write Below	☐

New Patient History

Dr. Kovacev
Board Certified in General Surgery

Name: _____ Birthday: _____

Social History:

Marital Status: (Check) Married Divorced Widowed Cohabitate Single

Number of Children: _____ Highest Education Completed: _____

Employer: _____ Years at current job: _____

Tobacco Use: (Circle) Never Current: How many years smoking: _____

How Much Do You Smoke and How Often: _____

Do You Use Recreational Drugs (Marijuana, Prescription, etc):_____

Have you EVER Used Recreational Drugs: YES NO If yes, when last? _____

Alcohol Use: (how much and how often): _____

Do You Exercise (how much and how often): _____

Have You Had Any Known Exposure to Chemicals / Radiation or Other Environmental Factors of Concern? (asbestos, benzene, chemicals at work, ect.). If so please explain below:

_____

Have You Had Any Recent or Past Viral Infections?	YES ☐	NO ☐
Have You Had Any Sexually Transmitted Diseases?	YES ☐	NO ☐
Do You Get Regularly Immunized (flu, etc.)?	YES ☐	NO ☐
Have you used Vapor or Electronic Cigarettes?	YES ☐	NO ☐
Have You Abused Any Other Substances (bath salts, Freon, ect.)	YES ☐	NO ☐
Are You on Any Form of Disability or Public Assistance?	YES ☐	NO ☐
Have You Been Hospitalized in the Past 1 Year?	YES ☐	NO ☐

Who is your Primary Care Doctor? (write below)

_____

Name Address / City Phone

Is there anything you feel is important for Dr. Kovacev to know about you that is not listed?

_____

Covid Vaccine: Y ☐ N ☐ if yes which? _____ # Boosters ___ Date: _____