

ACCOUNT NUMBER

SURGICAL ASSOCIATES, P.C.

SET-UP DATE

PLEASE PRINT - PRESS DOWN HARD

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

PATIENT'S FULL NAME		LAST	FIRST	MIDDLE	DATE OF BIRTH	AGE
STREET ADDRESS				CITY, STATE, ZIP CODE		
HOME PHONE ()		CELL PHONE ()		E-MAIL ADDRESS		
SOC. SEC. NO.		MARITAL STATUS		SEX		
		<input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
PATIENT'S EMPLOYER		OCCUPATION (INDICATE IF STUDENT)		PART TIME <input type="checkbox"/>	FULL TIME <input type="checkbox"/>	BUSINESS PHONE ()
SPOUSE'S NAME						DATE OF BIRTH
SPOUSE'S EMPLOYER		OCCUPATION (INDICATE IF STUDENT)		PART TIME <input type="checkbox"/>	FULL TIME <input type="checkbox"/>	BUSINESS PHONE ()

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT)

NAME OF RESPONSIBLE PARTY		SOC. SEC. NO.	DATE OF BIRTH	HOME PHONE ()
STREET ADDRESS		CITY, STATE, ZIP CODE		RELATIONSHIP TO PATIENT
RESPONSIBLE PARTY'S EMPLOYER		OCCUPATION		BUSINESS PHONE ()
			PART TIME <input type="checkbox"/>	FULL TIME <input type="checkbox"/>

INSURANCE INFORMATION

ARE YOU INSURED UNDER YOUR SPOUSE'S INSURANCE?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	IF YES: NAME OF INSURANCE CO.	CONTRACT NO.	GROUP NO.
IS THIS A WORKMAN'S COMPENSATION CLAIM?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	DATE OF INJURY	WERE YOU INJURED IN A MOTOR VEHICLE ACCIDENT?	DATE OF MOTOR VEHICLE ACCIDENT
				YES <input type="checkbox"/>	NO <input type="checkbox"/>
			STATE		

IN CASE OF EMERGENCY NOTIFY (OTHER THAN RESPONSIBLE PARTY)

NAME	PHONE ()	RELATIONSHIP
STREET ADDRESS	CITY, STATE, ZIP CODE	

 WHOM MAY WE THANK FOR REFERRING YOU? _____
 NAME CITY/STATE

EXPLANATION OF PAYMENT POLICY AND INSURANCE FILING PROCEDURES

I hereby authorize Surgical Associates, P.C. to release all medical and/or related financial information to my insurance carrier(s) or other parties making payment for my medical services, as well as other physicians or medical care entities that request information in conjunction with my care and treatment.

I further authorize the payment of benefits directly to Surgical Associates, P.C. I understand that I am responsible for all charges not paid or covered by insurance and agree to pay any costs of collection including a reasonable attorney's fee.

I authorize treatment, care and testing as provided or recommended by Surgical Associates, P.C.'s physicians and staff.

DATE

SIGNATURE

FOR OFFICE USE ONLY

MEDICAL HISTORY

Surgical Associates, P.C. (Rev. July 15, 2004)

Name	Date of Birth	Age	Today's Date
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PLEASE PRINT

1. List allergies or sensitivities to any medications or substances such as Penicillin, Codeine, Novacaine, Xylocaine, Epinephrine, Latex, etc. If no known allergies, write NKA.

2. List all medications you take daily.

3. Do you take Coumadin, Plavix, Aspirin or other blood thinners? No Yes

4. Do you smoke? No Yes. How much? _____ For how long? _____

Do you drink alcoholic beverages? No Yes. How much? _____

5. Have you ever had any of the following?

Anemia	High Blood Pressure	Seizures
Poor Circulation	HIV/HTLV Infection	Stroke
Diabetes	Menstrual Problems	Ulcer Disease
Heart Problems	Mitral Valve Prolapse	Respiratory Problems
Hepatitis	Cancer	If yes, what kind?
Other		

6. Describe any surgery you have had in the past:

Date of surgery	Type of Procedure	FOR OFFICE USE ONLY

7. If you have a family history of the following, indicate what relation to you. If none, leave blank.

Breast Cancer	Cancer
Diabetes	Heart Disease
High Blood Pressure	Tuberculosis

REVIEW OF SYSTEMS
Surgical Associates, P.C. (Rev. June 24, 2004)

Name (Please Print)	Date of Birth	Age	Today's Date
Referring Physician		Primary Care Physician (if different from Referring Physician)	
Reason for today's visit?			

Please check all that apply:

General:

- Weakness or Fatigue
- Recent weight change
- Fever

Head, Ears, Eyes, Nose, Mouth, Throat:

- Frequent nose bleeds
- Swollen glands
- Difficulty swallowing

Cardiovascular:

- High blood pressure
- Abnormal heart beat – skipped or extra beats
- Enlarged heart, abnormal heart or heart failure
- Treated for chest pain or heart attack

Respiratory:

- Severe shortness of breath
- Coughing up blood
- Asthma

Gastrointestinal:

- Recurrent indigestion or heartburn
- Major changes in bowel movements – size, frequency, stool appearance, etc.
- Rectal bleeding
- Nausea or vomiting
- Chronic intestinal problems

Genitourinary:

- Bladder or kidney infections
- Blood in urine
- Kidney Stones
- Difficulty urinating

Musculoskeletal:

- Walking or balancing difficulties
- Frequent muscles cramps

Breast:

- Nipple discharge or discoloration
- Breast mass or lumps
- Extreme breast tenderness
- History of breast infection or injury

Skin:

- History of skin cancer: type?/ location?

- Change in a mole or birth mark: location?

Neurological:

- Seizures
- Fainting or blackouts

Endocrine:

- Thyroid trouble
- Diabetes

Hematologic/Lymphatic:

- Anemia/ low blood count
- Tendency for bleeding or severe bruising
- Blood Clots
- History of chronic infections/ swollen lymph nodes/ glands

Allergic/Immunologic:

- HIV positive
- Tuberculosis/ positive skin test
- Hepatitis

FEMALES ONLY: Are you pregnant? No Yes. If you have children, how many?

Date of your last period?

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT (Form 100)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and care among multiple healthcare providers.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Surgical Associates, P.C. has the right to change its *Notice of Privacy Practices* from time to time and that I may contact them at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

As provided for by HIPAA, and as described in the *Notice of Privacy Practices*, Surgical Associates, P.C. may use or disclose my health information for treatment, payment or healthcare operations. Therefore, unless I specifically object, Surgical Associates, P.C. may disclose to a member of my family, a relative, a close friend, caregiver or any other person I identify, my personal information that directly relates to that person's involvement in my care.

*Please list those individuals below that you would wish to use as **Contacts** to discuss your care as needed:*

Contacts: (List by name)

- Spouse _____
- Father _____
- Adult Children _____
- Other _____
- Other _____
- Other _____

Mother _____

Printed Patient Name

X
Signature

Date

Relationship if other than patient signature

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Reason: _____

Date: _____ By: _____