Patient Information Form

PATIENT: ____ **DATE:** ______________
FIRST **MIDDLE** **LAST**

ADDRESS: ____
STREET **CITY** **STATE** **ZIP**

HOME PHONE: _________________________ **CELL:** _____________________________

BIRTHDAY: ____________ **SOCIAL SECURITY #:** ___________________

SEX: o MALE o FEMALE o TRANSGENDER **EMAIL:** _________________________________

ETHNICITY: o HISPANIC OR LATINO o NOT HISPANIC OR LATINO

MARITAL STATUS: o SINGLE o MARRIED o DIVORCED o WIDOWED o SEPARATED

RACE: o AMERICAN INDIAN OR ALASKA NATIVE o ASIAN o BLACK OR AFRICAN AMERICAN
o HISPANIC o WHITE o NATIVE HAWAIIAN
o OTHER RACE o OTHER PACIFIC ISLANDER

LANGUAGE: o ENGLISH o SPANISH o OTHER _____________________________________

EMPLOYER: ____

EMPLOYMENT STATUS: o **FULL-TIME** o **PART-TIME** o **RETIRED**
o **DISABLED** o **HOMEMAKER** o **STUDENT**

EMPLOYER PHONE: ________________

WHO REFERRED YOU? ____

WHO IS YOUR PRIMARY CARE PHYSICIAN? _______________________________________

WHAT IS YOUR PREFERRED PHARMACY? _______________**LOCATION?** _______________

RESPONSIBLE PARTY (IF OTHER THAN PATIENT): __________________________________

ADDRESS: ____

HOME PHONE: __________________________ **CELL PHONE:** _______________________

RESPONSIBLE PARTY'S EMPLOYER: ____

OCCUPATION: _____________________________ **WORK PHONE:** _________________________

SOCIAL SECURITY NUMBER: ___________________ **DATE OF BIRTH:**___________________

WHO MAY WE CONTACT IN CASE OF EMERGENCY OR IF WE ARE UNABLE TO REACH YOU?

NAME: ___________________ **RELATIONSHIP:** ___________ **PHONE:** ___________________

Insurance Information

PRIMARY INSURANCE: __________________ **SECONDARY INSURANCE:** _______________

o **I HAVE NO INSURANCE COVERAGE**

o **THIS IS A WORKER'S COMPENSATION CLAIM** **CLAIM NUMBER:** ____________________

BENEFIT ASSIGNMENT/CONSENT/PRIVACY AND HIPAA POLICY

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private, HMO/PPO and commercial insurances as well as third party payers to **ADVANCED SURGICAL ASSOCIATES, LLC**. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for charges not covered by my insurance plan including both Medicare and/or Medicaid (Title XIX or Title XX benefits).

ADMINISTRATIVE AND FINANCIAL POLICIES

We are committed to providing you with the best care and are pleased to discuss our professional fees with you at any time. Your understanding of our financial policy is important to our professional relationship. Please ask if you have questions about our fees, financial policy or your responsibility.

1. All patients must complete the New Patient Information Form prior to being seen by the physician. You will be asked to update this information periodically. Failure to provide necessary information may require that your appointment be rescheduled or cancelled.
2. You must present your insurance card each time you are seen in our office. If you do not have your insurance card on the initial visit we will reschedule your appointment. A picture ID is also required.
3. **All Fees are due and payable at the time of your appointment**. If we are contracted with your insurance carrier, you will be responsible for the **co-pay** at the time of service. You will be billed for any remainder (patient responsibility) after we have received a response from your insurance carrier.
4. A PO Box address is not acceptable on our patient information sheet. We ***must*** have a physical address.
5. Your Social Security number must be on our patient information sheet.
6. **We charge $30.00 for <u>each</u> FMLA, disability or insurance form that pays you or gives you permission to be relieved temporarily from your employment**. This charge also extends to the faxing of records or the writing of a letter to the above mentioned.
7. There is a $30.00 return check charge on all returned checks.
8. It is your responsibility to know what hospitals and facilities participate with your health insurance plan.
9. All inactive patient records are destroyed after (7) seven years.
10. **We will reserve the right to charge a $50.00 No Show Fee** in the event you do not cancel your appointment within 24 hours of your scheduled appointment.

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for ADVANCED SURGICAL ASSOCIATES, LLC. to furnish medical care and treatment to (patient/guardian) *_____________________________________ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

PRIVACY RULE

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice. You may review Advanced Surgical Associates, LLC's notice of privacy practices on their website or you can ask for a copy at the time of your office visit. The signing of the consent form verifies that you have received the "Notice of Privacy Practices" information pamphlet as mandated by the Health Insurance Portability Act of 1996(HIPAA) and have been given the opportunity to review it.

CONSENT TO LEAVE A MESSAGE

Advanced Surgical Associates, LLC, in compliance with HIPAA guidelines, is very concerned with your privacy in relationship with your medical care. Please specify person (s) with whom we may discuss your personal health information. (Check all that apply):

o ALL RELATED MEDICAL CONDITIONS AND/OR TEST RESULTS MAY BE DISCUSSED WITH THE FOLLOWING INDIVIDUALS:

NAME: ______________________ RELATIONSHIP: ___________________ PHONE: _______________
NAME: ______________________ RELATIONSHIP: ___________________ PHONE: _______________

o MESSAGES MUST ONLY CONTAIN CALL BACK INFORMATION.

o IS IT PERMISSIBLE TO LEAVE MESSAGES AND/OR TEST/LAB RESULTS VIA:
ANSWERING MACHINE o YES o NO VOICEMAIL o YES o NO

RELEASE OF INFORMATION

I hereby authorize said assignee to release all medical information necessary, including Medical Records, to any carrier listed on my patient information for the purposed of processing any insurance or workman's compensation claim to secure payment. I also authorized release of information to any hospital/facility, ancillary provider or physician I may be referred to by this office.

***Patient Signature:____ Date:______________________**

REVIEW OF SYSTEMS

PLEASE MARK YES OR NO

GENERAL:

FATIGUE o Yes o No
FEVER o Yes o No
CHILLS o Yes o No
HEADACHE o Yes o No
WEIGHT LOSS o Yes o No
WEIGHT GAIN o Yes o No

ENT:

CHANGES IN HEARING o Yes o No
CHRONIC SINUS ISSUES o Yes o No
THROAT PAIN/SWELLING o Yes o No

CARDIOVASCULAR:

CHEST PAIN AT REST o Yes o No
CHEST PAIN W/EXERTION o Yes o No
ARRHYTHMIA o Yes o No
PALPITATIONS o Yes o No
HIGH BLOOD PRESSURE o Yes o No
SWELLING OF ANKLES o Yes o No

RESPIRATORY:

COUGH o Yes o No
SHORTNESS OF BREATH o Yes o No
WHEEZING o Yes o No

GENITOURINARY:

BLOOD IN URINE o Yes o No
FREQUENT URINATION o Yes o No
PAINFUL URINATION o Yes o No

MUSCULOSKELETAL:

PAINFUL JOINTS o Yes o No
SWOLLEN JOINTS o Yes o No

ENDOCRINE:

DIABETES o Yes o No
THYROID DISEASE o Yes o No

NEUROLOGIC:

WEAKNESS	oYes o No
DIZZINESS	oYes o No
NUMBNESS	oYes o No
GAIT ABNORMALITY	oYes o No

HEM/LYMPH:

EASY BRUISING/BLEEDING	oYes o No
ANEMIA	oYes o No
SWELLING	oYes o No

SKIN:

RASH	oYes o No
SKIN LESION	oYes o No
SKIN OOZING	oYes o No

OPTICAL:

BLURRED VISION	oYes o No
DISCHARGE	oYes o No
REDNESS	oYes o No
PAIN	oYes o No

GASTROINTESTINAL:

ABDOMINAL PAIN	oYes o No
NAUSEA	oYes o No
DIARRHEA	oYes o No
VOMITTING	oYes o No
CONSTIPATION	oYes o No
RECTAL BLEEDING	oYes o No
RECTAL PAIN	oYes o No
BLOATING	oYes o No

OTHER SYSTEM COMPLAINTS:____

____

Patient Name: ___________________________ **Date of Birth:** _______________ **Date:** ______________

MEDICATIONS AND DOSAGE (including aspirin and over the counter medications or provide separate list)

MEDICATION NAME	DOSAGE	MEDICATION NAME	DOSAGE

Allergies and Reactions: ____

____

CHIEF COMPLAINT—Why are you here today? ____

____

ADVANCED DIRECTIVE/ LIVING WILL? o Yes o No

PATIENT PRIOR HOSPITALIZATIONS	WHEN?	PRIOR SURGERIES/OFFICE PROCEDURES	WHEN?

PATIENT SOCIAL HISTORY

Smoker? o Yes o No
How many packs daily? ______
How many years? __________
Interested in stopping? o Yes o No
Do you smoke Marijuana? o Yes o No

Alcohol Drinker o Yes o No
Type ___________________
Amount _________________

Trouble sleeping? o Yes o No
Do you snore? o Yes o No
Daytime drowsiness o Yes o No

Coffee Drinker o Yes o No
How many cups daily? ______
Other caffeine? ____________

Female Patients Only:
Pains or cramps: o Yes o No
Regular Periods: o Yes o No o Varies
Complications w/ pregnancy: o Yes o No
How many Cesarean Sections: ________
How many children born alive: ________
How many miscarriages: _____________
Have you had a hysterectomy: o Yes o No
Are you pregnant: o Yes o No
Last Menstrual Period: _______________
Date of Last Mammogram:

PATIENT MEDICAL HISTORY

ARTHRITIS	Yes No	KIDNEY DISEASE	Yes No
CANCER	Yes No	MENTAL ILLNESS	Yes No
DIABETES	Yes No	THYROID DISEASE	Yes No
HEART DISEASE	Yes No	STROKE	Yes No
HYPERTENSION	Yes No	DATE OF LAST COLONOSCOPY:	______________

FAMILY MEDICAL HISTORY

Condition	Father	Mother	Father's Parents	Mother's Parents	Siblings	Age Deceased
Heart Disease						
Hypertension						
Stroke						
Cancer (indicate type)						
Diabetes						
Kidney Disease						
Thyroid Disease						
Crohn's Disease						
Diverticulitis/losis						