Surgical Care of Southern WV

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____

MAILING ADDRESS: _____ CITY: _____ ZIP: _____

EMAIL ADDRESS: N/A

MALE _____ FEMALE _____ SOCIAL SECURITY #: _____

MARITAL STATUS: SINGLE _____ MARRIED _____ DIVORCED _____ WIDOW _____

EMPLOYER'S NAME and ADDRESS _____

>> PLEASE PROVIDE TWO WORKING TELEPHONE NUMBERS SO THAT WE CAN CONTACT YOU<<

HOME _____ CELL/OTHER _____ WORK _____

EMERGENCY CONTACT: NAME _____ RELATIONSHIP _____

EMERGENCY CONTACT PHONE NUMBER: _____

REFERRING PROVIDER: _____ PHONE: _____

PREFERRED PHARMACY: _____ PHONE: _____

>> IF THE PATIENT IS UNDER 18 YEARS OF AGE:

GUARDIAN NAME: _____ RELATIONSHIP _____

DATE OF BIRTH: _____ SS # _____

IF SAME ADDRESS AND PHONE AS PATIENT, CHECK HERE _____, IF DIFFERENT:

ADDRESS: _____

PHONE NUMBER: _____

BILLING/INSURANCE INFORMATION

SELF PAY: YES _____ NO:_____ (IF NO, PLEASE FILL OUT REMAINING INFORMATION)

PRIMARY INSURANCE: _____

ID #: _____

POLICYHOLDER'S NAME _____ DATE OF BIRTH _____

SECONDARY INSURANCE: _____

ID #: _____

POLICYHOLDER'S NAME _____ DATE OF BIRTH _____

***THERE ARE MULIPLE PAGES TO FILL OUT, PLEASE COMPLETE THEM ALL TO THE BEST OF YOUR ABILITY. THANKS! ☺

Financial Policy

- → We strongly feel that all patients deserve the very best medical care that we can provide. Everyone benefits when financial agreements are agreed upon. We have prepared this material to acquaint you with our policies.
- → Our professional services are rendered to you, not the insurance company. Payment for treatment is YOUR responsibility.
- → There will be a $25.00 charge on all returned checks

Please read the following carefully and initial beside the statements that apply to you:

Financial Agreement

_____ I have no insurance coverage. I understand that I am responsible for payment of service at the time of service. (for self pay patients only)

_____ I understand that if I fail to pay the amount owed, the clinic has the right to secure an outside collection agency and/or attorney to collect the unpaid debt and to report the debt to a credit reporting agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collecting agency or attorney, including reasonable attorney's fees.

Authorization and Assignment to Insurance Company

_____ I hereby authorize the release of any information necessary to process insurance claims and request payment of benefits to be made for services rendered to myself or dependents.

_____ I understand that I am responsible at the time of service for paying any required co-pays and deductibles.

Medicare Patients Only

I authorize any holder of medical or other information about me to release to the SSA or its intermediaries or carried any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits, either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible of paying for my treatment. Regulations pertaining to Medicare assignment also apply.

I have read and understand the payment policy and agree to abide by the said policy.

Signature _____ Date _____

NAME: _____

DATE OF BIRTH: _____

RELEASE OF INFORMATION/HIPAA

- I hereby give authorization to release my medical information to the following people that I have listed
- *** If I choose not to list any one person, NO information will be given out for any reason ***

*Please list ALL people you wish information to be given to if the situation arises that your medical history may need to be discussed with someone other than yourself. (Example: spouse, children, significant other, parents, siblings)

- _____
- _____
- _____
- _____

_____ PLEASE CHECK HERE IF YOU DO NOT WANT ANY INFORMATION GIVEN TO ANY ONE PERSON.

SIGNATURE: _____ DATE: _____

RECEIPT OF NOTICE OF PATIENT RIGHTS AND NOTICE OF PATIENT PRIVACY

- I have received a copy of the Notice of Patient Rights and the Notice of Patient Privacy (the stated documents are available at any given time in our office lobby) at Surgical Care of Southern WV.

x _____

Patient Name and Signature Date

If patient is unable to sign or under the age of 18, notice is given to:

x _____

Name and Signature/ Relationship to patient Date

NOTICE TO PATIENTS WITH SMARTPHONES!!

If you have provided us with a cell phone number, at some point after your visit, you will automatically receive a TEXT from our office which will appear to be from UCARE or CareNotify. The text will ask you to click on a link which will take you to your Summary of Care for your visit. It will give you the opportunity to review your visit along with your current plan of care. You will have the option to view it or not view it. IF YOU CHOOSE NOT TO VIEW THE MESSAGE, REPLY "NO" and it will opt you out of this service. This is a secure message and once you have read your message, it will be deleted from your phone. We want to assure you, once again, that this is a SECURE message you DO have the option to opt of this service. We hope you take advantage of this service as we strive to give you the best of care!

Primary care physician:_____

Referring physician:_____

Preferred Pharmacy:_____

Reason you are being seen today:_____

ALLERGIES (List all medication, food, and environmental allergies with your reaction. If you do not have any allergies, write NONE.)

ALLERGY	REACTION

MEDICATIONS (List every medication you are taking including prescriptions, vitamins, herbal supplements, and over the counter medications.)

NAME OF MEDICATION	DOSE

MEDICAL HISTORY

Please list all of your current and past medical problems.

If you are a female:

When was your last period? _____When was your last mammogram?_____

Are you now, or could you be pregnant?_____

SURGICAL HISTORY

Please list all of your previous surgeries and when they were done.

SURGERY	DATE

Have you had a COLONOSCOPY in the past? _____When was it done? _____

Where was the colonoscopy done?_____

SOCIAL HISTORY

This helps us to better know you and have an idea of your risk factors. Please circle or write in the answers.

Do you smoke? YES NO

If yes, how much do you smoke each day? _____Packs per day _____Cigars per day

How many years have you smoked? _____Years

How much alcohol do you drink? _____ PER DAY PER WEEK

Do you use chewing tobacco? YES NO

List any other drugs you use and how often you use them._____

_____

Marital status: MARRIED DIVORCED SINGLE

Occupation:_____

What is your highest level of education?_____

Do you have and Advanced directive or Power of attorney? YES NO

If yes? What is their name and relation to you:_____

FAMILY HISTORY

Please list the medical problems that members of your family have.

Mother:_____

Father:_____

Grandparents:_____

Brothers:_____

Sisters:_____

Other:_____

Does anyone in the family have the following if not listed above and if yes, who

Medical disease	Who had or has this
Colon cancer	
Breast cancer	
Ovarian cancer	
Pancreatic cancer	
Diabetes	
Heart disease	

REVIEW OF SYSTEMS

We need to have records about your general medical health. This form is broken up into different areas. If you are not having any problems in the area, please CIRCLE "no problems." If you are experiencing any of the symptoms listed, please CIRCLE those that apply to you. Please write out any problems that you do not see listed.

CONSTITUTIONAL (Health in General): No Problems. Fever, weight loss, weight gain, fatigue, loss of appetite. Other:_____

EARS, NOSE, MOUTH &THROAT: No Problems. Wears glasses, hard of hearing, use hearing aides, eyes have turned yellow, nosebleeds, Sinus problems, dentures, loose teeth, tooth problems. Other:_____

CV (HEART&BLOOD VESSELS): No Problems. High Blood pressure. Chest pain, irregular heartbeat, racing heart, pain in legs with walking, leg swelling, heart murmur, history of heart attack, history of heart failure.
Other:_____

RESPIRATORY (LUNGS&BREATHING): No Problems. Chronic cough, Wheezing, Blood in sputum, shortness of breath, use oxygen at home, sleep apnea, abnormal CXR.
Other:_____

BREAST/CHEST: No problems. Lump, pain, nipple discharge, Rash, History of breast biopsy, History of hormone replacement use.
Other:_____

GI (STOMACH&INTESTINE): No problems. Abdominal pain, Heartburn/reflux, Difficulty Swallowing, Nausea, Vomiting, Constipation, Diarrhea, Change in bowel habits, Blood in stools, Incontinent of stool. Other_____

GU (KIDNEY&BLADDER): No problems. Frequent UTI, Blood in the urine, Incontinence, decrease in urinary stream, prostate problems, renal failure, on dialysis.
Other:_____

INTEGUMENTARY (SKIN): No problems. Persistent rash, new skin lesion, dry skin. Other:_____

ENDOCRINE (GLANDS): No problems. Diabetes, frequent thirst or urination, hypothyroid, hyperthyroid, temperature intolerance (too hot or too cold), night sweats, hot flashes, menstrual changes. Other:_____

HEMATOLOGIC (BLOOD&LYMPH): No problems. Bruise easily, Problems with bleeding, Anemia, History of blood clots in legs, History of blood clots to lungs.Other:_____

ALLERGIC/IMMUNOLOGIC: No problems. Seasonal allergies, Sneeze, Runny nose, Swollen glands, HIV, Hepatitis B, Hepatitis C. Other:_____

MS (MUSCLES, BONES, JOINTS): No problems. Arthritis, Fibromyalgia, Connective tissue disorder, Lupus, Back pain. Other:_____

NEUROLOGIC (BRAIN&NERVES): No problems. Headaches, Dizziness, Weakness, Problems with walking/balance, loss of consciousness, Parkinson's, Dementia, History of stroke, History of seizures. Other:_____

PSYCHIATRIC (MOOD): No problems. Depression, Anxiety, PTSD. Other:_____