Patient Information Form

Last Name: _____ First Name: _____ Middle Initial:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____Date of Birth: _____

Social Sec#: _____ Marital Status: _____ Email Address:_____

Preferred method of contact (circle one): Voice Text Email //// ***WOULD YOU LIKE ACCESS TO PT PORTAL? Y N***

Primary Care Physician: _____ Phone# _____

Referring Physician: _____ Phone# _____

For treatment purposes your records will be sent to the physicians stated above unless you inform us otherwise.

_____

If you were not referred, how did you hear about us? Search Engine/Website Family/Friend Other

Please provide us with your pharmacy information to expedite prescription pick up.

Pharmacy Name: _____Phone#_____

Address or Intersection: _____

Guarantor Information: (Please list person responsible for bill-use full legal name)

Relationship of Guarantor to Patient: Self ____ Parent(**if under 18 only**)___ Guardian/Power of Attorney____

Last Name: _____ First name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Date of Birth: _____ SS Number: _____

PLEASE GIVE ANY INSURANCE CARDS AND DRIVERS LICENSE OR OTHER FORM OF ID TO FRONT DESK

Primary Insurance Company: _____

Ins Phone# _____ Policy Holders Name: _____

Policy Holders Date of Birth: _____ Policy Holder SS# _____

Secondary Insurance Company: _____

Ins Phone # _____Policy Holders Name: _____

Policy Holders Date of Birth: _____ Policy Holders SS# _____

Relationship to Pt: _____ Policy Holders Employer: _____

Policy Holders Employer: _____Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____ Phone # _____

HIGHLANDER SURGICAL ASSOCIATES

CONSENT FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

*The consent you are about to read was written by the Texas Medical Association and requires that all physicians have patient consent for general treatment. ***

"I, knowing that I am suffering from a condition requiring, diagnostic evaluation, medical or surgical treatment, or other form of necessary treatment, do hereby voluntarily consent to such procedures and care during my episode of care or other services under the general and specific instructions of the Physician(s), or their designee(s) as is necessary in their judgment. I also acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the result of treatments or examinations by Jason Harrison, MD, PA, dba. Highlander Surgical Associates (collectively referred to herein as "HSA"). I further understand that all options will be discussed prior to the administration of such examinations and / or treatment."---Texas Medical Association.

I hereby consent to the use and disclosure of my protected health information necessary for my medical care to other providers assisting or consulting in my medical care and to any parties necessary to process medical claims and participation in workers compensation programs or applications for financial benefits or to conduct the health care operations of HSA. I understand that diagnosis or treatment of me by a physician or designee of this practice may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. HSA is not required to agree to the restrictions that I may request. However, if HSA agrees to a restriction that I request, the restriction is binding on HSA and its physician(s) and staff. I have the right to revoke this consent, in writing, at any time, except to the extent that HSA has taken action in reliance on this consent.

My "protected health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This PHI relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review HSA's Notice of Privacy Practices prior to signing this document. HSA's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of HSA. This Notice of Privacy Practices also describes my rights and HSA's duties with respect to my protected health information.

HSA reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

TREATMENT OF MINORS (persons 17 years of age and under): Pursuant to Texas law, ***an additional and separate*** Consent for Treatment of Minors must be completed.

Furthermore, I have read, understand, and agree to the statements that appear herein.

PRINTED NAME: _____ **RELATIONSHIP TO PATIENT:** _____

SIGNATURE: _____ **DATE:** _____

WITNESSES NAME: _____ **WITNESSES SIGNATURE:** _____ **DATE:** _____

HIGHLANDER SURGICAL ASSOCIATES

FINANCIAL POLICY

Please be assured that everyone in this practice is dedicated to providing medical care of the highest quality possible to all of our patients, in an atmosphere of caring, trust and mutual respect.

We thank you in advance for taking time to review this policy. Your complete understanding of your financial responsibilities is essential; it takes a team that includes patient participation, to succeed with insurance processing and reimbursement. Failure by the insurance company to pay, results in the balance being transferred to the patient for payment.

Our practice policy requires that prior to any services being rendered; all patients must sign the practice financial policy.

We ask that you please present to the office with a form of payment (cash, check or credit card) to meet your obligations to your insurance provider and to your healthcare provider.

Please feel free to discuss any concerns or questions you may have with anyone of our billing staff or our practice manager. We would welcome the opportunity to assist you in your understanding of the complexities of health insurance today.

Things to bring with you to your visit:

- Health Insurance Card
- Drivers License or other form of government issued photo ID.
- Method of payment – for your convenience we accept checks, credit cards, debit cards and cash.
    - Please note a thirty dollar ($30.00) processing fee will be applied to any non-sufficient funds.
    - NSF may be referred to the Worthless Check Unit of the Tarrant County Office of the District Attorney, pursuant to Texas Penal Code Sec. 31.06

Assignment of Benefits:

- Jason Harrison, MD, PA, dba. Highlander Surgical Associates (collectively referred to herein as "HSA") will bill contracted and non-contracted insurance plans as a courtesy to our patients provided if the patient has provided the required insurance information in a timely manner and has signed a current financial policy and Assignment of Benefits form.

Co-pay, co-insurance and deductibles:

- Payment is due at the time services are rendered. This includes in or out of network coverage.
- Co-pay: We are obligated to collect the co-pay at the time of your visit. We are required to do so by your insurance plan. The co-payment amount is determined by your individual insurance policy.
- Deductible: Some insurance plans require that patients pay a predetermined dollar amount prior to services being covered. The amount of money you must pay each year to cover your medical expenses before your health insurance policy starts paying.
- Co-insurance: In addition to the deductible, health insurance plans may have a coinsurance. This is the amount you are required to pay for medical care in a fee-for-service plan after you have met your deductible. Coinsurance rate is usually expressed as a percentage. For example; if the insurance company pays 80 percent of the claim, you are responsible for 20 percent. This portion is due at time of service.
- At no time will co-pay, coinsurance or deductibles be waived.
- Minor Patients: For all services rendered to minor patients, we will look to the accompanying adult or custodial parent or guardian, for payment.
- Ultimately it is your responsibility to call your insurance company to determine what your schedule of benefits allows, if a deductible applies and your potential financial responsibility.

Self "cash" Pay/Fee for Service/Good Faith Estimate

- We offer a Good Faith Estimate for our 'cash pay/fee for service' patients who have no health insurance coverage in any form or wish not to use their health insurance. Please see the notice posted in our lobby.
- Prior to your visit, you will be provided the visit cost and will be required to pay in full at time of check in on the day of your appointment.
- Prior to any surgery, you will be provided an estimate of the surgery cost and will be required to pay in full prior to the surgery date.
- You will be asked to sign a waiver stating that you have no health insurance coverage and will not be filing with any health insurance carrier.

Collections- Referral for Outside collections

- In the event that a balance becomes past due, the account will be considered delinquent.
- Delinquent accounts may be subject to further collection action, including placement with a collection agency. Accounts that are placed with a collection agency now become the responsibility of the collection agency, Credit Systems International, Inc. In addition, all accounts placed with Credit Systems International, Inc will also be forwarded to three major credit bureaus in which will affect your credit report. The patient is responsible for the balance and any related fees.
- If your account has been forwarded to the collection agency, please contact the agency at: *Credit Systems International, Inc. 1227 Country Club Lane, Fort Worth, Texas 76112. Phone: 817/496-6500*
- Prior to providing additional services to you, payment in full of total outstanding balances will be required.

FMLA and other Disability Paperwork

- **Special forms are sometimes necessary to provide documentation of medical conditions. Completing forms is time consuming and falls outside of the contractual relationship between you and your insurance company.**
- **We are happy to complete the form(s) for you. Each form must be accompanied with a filing fee of $75.00 prior to completion. *Please allow 15 business days for completion.***

Charges for copies of medical records- With Proper signed consent.

- You may request your medical records to be sent to another physician. There is no charge.
- You will be charged for copies of medical records as per Texas Medical Association guidelines, if medical records are released to the patient. This is a pre-pay of twenty five dollars ($25) for the first 20 pages and fifty cents ($0.50) per page thereafter. These charges cover the administrative costs of copying and mailing such records.
- Please allow 15 business days for processing from the time of consent submission.

Phone Appointments

- If you need to discuss a healthcare issue or abnormal test results, you will be asked to schedule an appointment to see your provider.

Professional Courtesy

- Professional courtesy will not be offered in any form to our colleagues in the health related fields.

Refunds:

- Refunds are issued to the appropriate party. Patient refunds will not be processed until all active or past due charges are paid in full. Refunds less than $10.01 will not be issued unless requested.

My signature below attest that I have read, understand and acknowledge the above information and have been given the opportunity to ask questions and have had any questions answered.

Patient Signature: _____ Date: _____

Witness Name :_____ Witness Signature: _____ Date: _____

Highlander Surgical Associates, PLLC

LEGAL IRREVOCABLE ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND SUMMARY PLAN DOCUMENTS

I _____The undersigned (the "Patient"), having healthcare benefit coverage through a group (including a self-funded and employer/employee benefit plan), Medicare, Medicaid and/or individual healthcare plan (collectively, the "Plan"), hereby appoint and assign as my designated authorized representative, **Jason Harrison, MD, PA dba Highlander Surgical Associates, PLLC** (the "Provider"), and its billing agent, MedRevenue Solutions, LLC and/or designated business associates, the right to pursue payment for all benefits entitled under my plan or policy. This authorization includes, taking any and all necessary steps, including pursing administrative appeals, requesting disclosures and remedies, filing suit and all causes of action and all other protected rights wholly in my stead, for benefit payment of all medical benefits otherwise payable to the Patient for medical services, treatments, therapies, and/or medications rendered or provided by the Provider, regardless of the Provider's managed care network participation status. The Patient hereby appoints the Provider, its billing agent, MedRevenue Solutions, LLC and/or the Provider's appointed business associates, the Patient's rights, title, and interests in and to, and related to the recovery of, any and all benefits which the Patient is entitled to receive under the Plan or insurance policy, and authorizes the Provider to release all medical information necessary to pursue and process the Patient's benefits and claims thereunder. I certify that the health insurance information that I provided is accurate and that I am responsible for keeping it updated. I hereby authorize provider. to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) to be paid in full compliance of governing laws. I further authorize my plan, its fiduciaries, and/or its third-party administrators to release to my health care provider, its billing agent, MedRevenue Solutions, LLC and/or the Provider's appointed business associates, all EDI and other information necessary for my healthcare provider to claim such benefits. I also hereby instruct my benefit plan (or its administrator) to pay the Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to the provider, I hereby instruct and direct my benefit plan (or its plan administrator) to provide governing plan documentation stating such non-assignment to myself and the provider upon request and its standing to governing laws. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make the check payable to me and mail it directly to the provider. I understand there are state and federal consumer protections that support even for out of network providers that may be associated with my care or surgery, that I am responsible for co-payments, co-insurance, and deductibles at no more than my in-network cost share rate. I understand, agree and hereby certify that I am obligated to pay, as charged and billed for global service charges, regardless if the above services are covered under my health insurance or plan. I understand that "Deductible" is defined, under the Uniform Glossary from ERISA & the Patient Protection & Affordable Care Act (ACA) as: "*The amount you owe for healthcare services your health insurance or plan covers before your health insurance or plan begins to pay,*" and that I have no knowledge of any plan exclusion or limitation for the charges for healthcare services rendered by the above listed provider, in case that I can't afford to pay for 100% deductible. I understand the payments are due at the time of the services unless otherwise applicable to any PPO or ACA discount once my claim for benefits is processed in full compliance with plan terms and governing laws. I understand I am fully protected against any unexpected medical bills or charges by my provider's applicable ACA or indigency discount policy; including any non-compliant or arbitrary and capricious PPO Discounts or Re-pricing Discounts received from my health insurance plan. My satisfaction is guaranteed in connection with my provider's proactive reasonable efforts to collect or make a good faith determination for ACA Discount qualifications solely based on my unique ability to pay and individual health needs. I hereby assign billed charges for healthcare services rendered as my legal claims to the above listed provider as full payment.

I agree to assist as needed in obtaining all benefits entitled and due me for all healthcare services rendered. I hereby designate, authorize and appoint the Provider, MedRevenue Solutions, LLC, its attorneys or other designated business associate and as my authorized representative to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; (3) To file and participate in any administrative or judicial review process; (4) to give the provider and its attorneys standing to pursue payment and file suit for benefits and any fiduciary breach and all causes of action available under ERISA and Section 502, 27 § U.S.C. 1132(a). (5) to pursue all necessary benefit payments, appeal rights, remedies and all causes of action, wholly in my stead; (6) to pursue a claim for benefits and to recover all applicable penalties for any fiduciary breach or failure by my plan, its fiduciary and/or its claims administrator to comply with 29 USC § 1132 and (7) allow a photocopy of my signature to be used to process insurance claims. This authorization will remain in effect until all benefits are paid in full compliance of applicable federal and state laws. I hereby confirm and ratify all actions taken by my authorized representative pursuant to the authority granted herein. I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to the above-named health care provider or its designated business associated any and all relevant Plan and claim related documents, requested disclosures, complete insurance policy, and/or settlement information upon written request from the provider, its attorneys or designated business associates in order to secure and claim such medical benefits due and owed me under my plan or policy. I authorize the release or disclosure of my protected health information to my authorized representative in order to secure and claim medical benefits due; (1) obtain information or submit evidence regarding the claim to the same extent as me; (2) make statements about facts or law; (3) act as my authorized representative in connection with filing, providing or receiving notice of any claim or appeal proceedings, to include any external review by applicable state or Federal External Review Process. I understand that I will be held financially responsible for all fees accumulated for collection agency fees. Administrative fees, attorney fees and court costs incurred by the provider listed above for any delinquent account requiring outside collection assistance, to the fullest extent of the law. This order will remain in effect until revoked by me in writing. I understand revocation of this appointment will not affect any action taken in reliance on this appointment before my written notice of revocation is received. Unless revoked in writing, this assignment is valid for any and all requested administrative and judicial reviews rightfully due me under my governing plan or policy and to the fullest extent permitted by law. A photocopy of this assignment is to be considered valid, the same as if it was the original. I understand that, by signing this form, I am confirming my appointment of my designated authorized representative, the scope of my authorized representative's authority, and the option of the revoking of this appointment. **I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.**

_____	_____	_____
Patient/Guardian/Insured Signature	Employer Group Name Covering Benefits	Date

HIGHLANDER SURGICAL ASSOCIATES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

SUMMARY OF NOTICE OF PRIVACY PRACTICES

If you have any questions about this Notice please contact: our Privacy Officer.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or verbally, are kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, Highlander Surgical Associates prepared this summary explanation of how we are required to, and how this practice will maintain the privacy of your health information and how we may disclose your health information. A detailed explanation is available upon request from any of our office staff.

Highlander Surgical Associates may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

I. Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be referring you to another physician for a second opinion.
II. Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be submitting a claim, on your behalf, for your visit to your insurance company for payment to our office.
III. Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activity, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide you appointment reminders or information about treatment alternatives or other health-related benefits and services our practice offers that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization inwriting and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to our Privacy Officer, Highlander Surgical Associates, 301 Highlander Blvd Ste 101 Arlington, Texas 76018:

I. The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
II. Right to request restriction - Individuals will have the right to request that a covered entity restrict the disclosure of their protected health information of the individual and the covered entity must comply with the requested restriction except if the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment).
III. The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
IV. The right to inspect and copy your protected health information.
V. The right to amend your protected health information.
VI. The right to receive an accounting of disclosures of protected health information and electronic versions of protected health information.
VII. The right to obtain a paper copy of this summary version, or a detailed version of the notice from our office upon request.
VIII. Right to Provide an Authorization for Other Uses and Disclosures.
IX. Right to File a Complaint.

We are required by law to maintain the privacy of your protected health information and to provide you with the notice of our legal obligations, duties and privacy practices with respect to your protected health information.

This notice is effective as of June 13, 2011 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our Privacy Officer or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the associated policies and procedures of this office. We will not retaliate against you for filing a complaint.

For more information or to file a complaint with our Privacy Officer:Tel: 817/419-9200 during regular business hours or in writing at:***Privacy Officer, Highlander Surgical Associates, 301 Highlander Blvd Ste 101 Arlington, Texas 76018.***

For complaints involving covered entities located in Arkansas, Louisiana, New Mexico, Oklahoma, or Texas:
Region VI: Office for Civil Rights
US Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202
Voice Phone (214) 767-4056. FAX (214) 767-0432. TDD (214) 767-8940

HIGHLANDER SURGICAL ASSOCIATES

NOTICE OF PRIVACY PRACTICES:

Acknowledgment of Receipt

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices of Highlander Surgical Associates.* Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information and your rights related to the Use and Disclosure of your protected health information. We encourage you to read it in full. The most current version was updated September 23, 2013.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by: *Requesting a copy from our office at Highlander Surgical Associates, 301 Highlander Blvd Ste 101 Arlington, Texas 76018, or calling 817/419-9200.*

If you have any questions about our *Notice of Privacy Practices,* please contact:

Privacy Officer, Highlander Surgical Associates, 301 Highlander Blvd Ste 101, Arlington, Texas 76018,

or calling 817/419-9200

I acknowledge receipt of the *Notice of Privacy Practices of Jason Harrison, MD, PA, dba. Highlander Surgical Associates.*

Name: _____ Relation to Patient: _____

Signature: _____ Date: _____

Witness Name: _____ Date: _____

Witness Signature: _____

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, and the reasons why the acknowledgment was not obtained:

☐ Notice of Privacy Practices Given - Patient Declined to Sign

☐ Notice of Privacy Practices Given - Patient unable to sign:

Unconscious
Communication / Language Barrier
Other reason patient / legal representative unable to sign: _____

Name of Privacy Officer: _____

Signature of Privacy Officer: _____ Date: _____

Acknowledgment of Additional Information

Sharing Information:

I hereby give Jason Harrison, MD, PA, dba. Highlander Surgical Associates (collectively referred to herein as "HSA") office permission to disclose and discuss any medical/billing information, appointments/scheduling to/with the following family member(s), other relative(s) and/or close friend(s):

1. _____ Relationship: _____ DOB _____ PHONE _____

2. _____ Relationship: _____ DOB _____ PHONE _____

____ I do not wish to give permission for any family members, relatives or close friends to have any access to any information regarding my medical condition or treatment.

How to be contacted:

Please print the telephone number where you want to receive calls about appointments, lab and test results, billing and insurance inquiries, or other health care information. _____

May confidential messages (appointment reminders, lab and test results, billing and insurance inquiries) be left on the answering machine/voicemail at the number given above? **YES** **NO** **please circle one**

Who may we contact in case of an emergency? _____ Phone number _____

Updates of Information

If any changes in address, phone number or insurance occur, it is the responsibility of the responsible party to inform HSA of this change.

Work Related Injury

Please indicate if you believe this injury/illness is work related.

NO this is not a work related injury/illness _____ **(Signature Required)**

YES this IS a work related injury/illness _____ **(Signature Required)**

Our office **does not** accept or file Texas Workers Compensation claims. If you believe your injury is work related, please see someone at the front desk so your situation can be addressed.

Patient Signature

By signing below I am verifying that I have read and understand each of the six sections on this page. I also agree that the names listed in section 1 were assigned by me.

_____ _____ _____

(Patient/Legal Representative Signature) (Legal Representatives Relationship to Patient) (Date)

_____ _____ _____

(Patient's Printed Name) (Witness Signature) (Date)

Social History

EXERCISE: Do you currently exercise? Never ☐ Daily ☐ Weekly ☐ Type: _____

ALCOHOL:

Do you drink alcohol: Never ☐ Rarely ☐ Regularly ☐

How many standard glasses do you drink per day? _____

How many days do you drink per week? _____ Beer ☐ Wine ☐ Spirits ☐

SMOKING: cigarettes ☐ pipe ☐ cigars ☐

Do you smoke? ☐Yes ☐ No ☐Never If yes: how many per day?_____

Have you smoked in the past? ☐Yes ☐ No If so, how many per day? _____

For how many years _____ When did you stop smoking? _____

Allergies: Drug and Food

IF NO ALLERGIES, PLEASE WRITE NONE

Drug/Food/Dressings	Reaction

Are you allergic to LATEX? YES NO Reaction: _____

Current Medications

Include all Herbal Medication, Vitamins and Blood Thinners:

Name	Dose	Frequency	Reason

If you wish, a copy of your medications can be scanned into your chart.

Please circle 'Y' for YES to the following symptoms you are currently experiencing and 'N' for NO to the symptoms you are not feeling today or within the past week.

GENERAL:

Y N Fever
Y N Chills
Y N Weight Loss
Y N Weight Gain

EYES/EARS/NOSE/THROAT

Y N glasses or contacts
Y N discoloration of eyes
Y N thyroid mass
Y N hearing aids
Y N dentures
Y N nasal congestion/discharge

BREASTS:

Y N lumps
Y N tenderness
Y N nipple discharge
Y N mammogram
Year_____

HEART:

Y N chest pain
Y N irregular heart beats
Y N high blood pressure
Y N heart disease
Y N pacemaker/surgery
Cardiologist:_____

RESPIRATORY:

Y N cough
Y N sleep apnea
Y N asthma
Y N COPD
Y N emphysema

GASTROINTESTINAL:

Y N abdominal pain
Y N heart burn/GERD
Y N bloating
Y N nausea
Y N vomiting
Y N difficulty swallowing
Y N diarrhea
Y N constipation
Y N blood in stools
Y N hemorrhoids
Y N rectal pain/pressure
Y N ulcers
Y N last colonoscopy _____
Y N upper scope (EGD) _____
Performing Physician:_____
Y N Barrett's esophagus
Y N Crohn's Disease
Y N Ulcerative Colitis

GENITOURINARY

Y N kidney problems
Y N poor bladder control
Y N blood in urine
Y N scrotal mass
Y N scrotal pain
Y N pregnancy
Y N PAP YR _____
Y N Prostate Exam Yr_____

SKIN:

Y N rash
Y N itching
Y N new skin lesion

MUSCULOSKELETAL

Y N joint pain
Y N back pain
Y N arthritis

HEMATOLOGY:

Y N blood thinning meds
Y N easy bleeding
Y N easy bruising
Y N hepatitis
Y N AIDS/HIV

NEUROLOGIC:

Y N tingling/numbness
Y N muscular weakness
Y N seizures

ENDOCRINE:

Y N diabetes
Y N thyroid disorder
Y N high cholesterol

PSYCHOLOGICAL:

Y N depression
Y N anxiety

ALLERGY:

Y N sinus allergy
Y N skin allergy

Immunizations:

Y N Influenza (Flu) Vaccine _____ approx date
Y N Pneumococcal Vaccine _____ year

Cancer_____

Please list any other medical conditions we have not included:_____

_____

Family Medical History

List any known illnesses or conditions.

Example:High blood pressure, High cholesterol, Heart disease, Diabetes, Stroke, Asthma, Any type of cancer

Please list any other condition(s) not listed.

Mother: _____ ___ No Illnesses

Father: _____ ___No illnesses

Siblings: _____ ___No illnesses

Maternal GM: _____ ___No illnesses

Maternal GF: _____ ___No illnesses

Paternal GM: _____ ___No illnesses

Paternal GF: _____ ___No illnesses

Hospitalizations and Surgical History

Date	Surgery/Illness	Reason	Length of Stay	Complications

Have you ever had any problems with anesthesia? **Yes** **No**

The information on the forms I have completed is accurate and complete to the best of my knowledge. I understand that withholding any information regarding my health may cause harm to possible treatments.

_____ _____ _____

(Patient/Legal Representative Signature) (Legal Representatives Relationship to Patient) (Date)

_____

(Patient's Printed Name)