

Patient Information Form

Who referred you here: _____ Physician Family/Friend Other Pharmacy Name & Location: _____

Patient Information Name: _____ (Legal Name) Age _____
Last First Middle

Patient Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Birth: _____ Sex: **F** **M** Marital Status: **M** **S** **W** **D**

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Email Address: _____

Language: English Spanish Japanese Other Unavailable Ethnicity: Non-Hispanic Hispanic Declined Unavailable

Race: African American/Black American Indian/Alaskan Native Caucasian/White Native Hawaiian Other Declined Unavailable

Disabled Retired Unemployed Student Employed Employer Name & Address: _____

Preferred Communication: Patient Portal Mail Phone (Home) Phone (Cell) Phone (Work) Patient Occupation: _____

Emergency Contact: _____ Relationship to Patient: _____ Phone # _____

Parent Information (For Minors Only)

Primary Custodial Parent:	Date of Birth:
_____	_____
Last First Middle	City State Zip
Mailing Address: _____	_____
Social Security #: _____	Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____	Employer Name & Address _____
Other Parent:	Date of Birth:
_____	_____
Last First Middle	City State Zip
Mailing Address: _____	_____
Social Security #: _____	Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____	Employer Name & Address _____

Guarantor Information

Guarantor Name:	Date of Birth:
_____	_____
Last First Middle	City State Zip
Mailing Address: _____	_____
Social Security #: _____	Home Phone: _____ Cell Phone: _____ Work Phone: _____
Employer Name & Address _____	_____

Is your visit due to an injury on the job? _____ **Is Workers Compensation Involved?** _____

Insurance Information:

Our goal is to file your insurance correctly; a front and back copy of your current card will help ensure this. If you do not have insurance, please check with the front desk regarding payment options that are available

Primary Insurance – Insured’s Name: _____	Insured’s Date of Birth: _____
Primary Insured’s Social Security #: _____	Policy Holder ID #: _____
Primary Insurance Name: _____	Primary Insured’s Employer: _____
Secondary Insurance – Insured’s Name: _____	Secondary Insured’s Date of Birth: _____
Secondary Insured’s Social Security #: _____	Secondary Policy Holder ID #: _____
Secondary Insurance Name: _____	Secondary Insured’s Employer: _____

Signature of Patient/Guardian _____ **Date** _____

Gastrointestinal:

- Anal Fissure/Fistulas Date _____
- Cirrhosis of Liver Date _____
- Colon Obstruction Date _____
- Constipation Date _____
- Crohn's Disease Date _____
- Diarrhea Date _____
- Diverticulitis of Colon Date _____
- Duodenal Ulcer Date _____
- Esophageal Reflux Date _____
- Fecal Impaction Date _____
- Fecal Incontinence Date _____
- Gallbladder Disease Date _____
- Gallstones Date _____
- GI Bleeding Date _____
- Hemorrhoids Date _____
- Hernia
 - Bilateral
 - Left Date _____
 - Right Date _____
 - Inguinal Date _____
 - Hiatal Date _____
 - Umbilical Date _____
 - Ventral/Incisional Date _____
- Irritable Bowel Syndrome Date _____
- Jaundice Date _____
- Nausea/Vomiting Date _____
- Peptic Ulcer Disease Date _____
- Pilonidal Cyst Date _____
- Recent Weight Loss Date _____ lbs _____
- Recent Weight Gain Date _____ lbs _____
- Rectal Bleeding Date _____
- Ruptured Spleen Date _____
- Stomach Ulcers Date _____
- Ulcerative Colitis Date _____
- Other: _____ Date _____

Genito-Urinary:

- Kidney Disease Date _____ Type _____
- Kidney Stones Date _____
- Urinary Tract Infections Date _____
- Other _____ Date _____

Eye Ear Nose Throat:

- Ear Problems Date _____
- Hearing Aids Wear Hearing Aid

Deaf

- Meniere's Disease Date _____
- Sinus Problems Date _____
- Visual Problems
 - Blind
 - Glaucoma
 - Wear glasses/contacts
 - Wear reading glasses
- Other _____ Date _____

Injury:

- Burns Date _____ Location _____
- Foreign Body Date _____ Location _____
- Fracture Date _____ Location _____
- Gunshot Wound Date _____ Location _____
- Stab Wound Date _____ Location _____
- Traumatic Injury Date _____ Type _____
- Other _____ Date _____

General Questions:

- Cancer Location _____
 - Treating Physician _____
 - Date _____
- Mass/Tumor Location _____
 - Date Found _____

Social History:

- Do you smoke? Yes Pks per day _____ How long? _____
- No
- If you have quit smoking when did you quit? _____ Date _____

- Do you drink alcohol? Yes, Amount per day? _____
- No

- Other drug use Yes Type _____
- No

Women Only:

- Are you pregnant? Yes Due Date _____
- No
- Age at onset of menstrual cycle: _____ Date of last period _____
- Number of pregnancies _____ Number of live births _____

Past Surgical History: (Check all that apply to you.)

- Appendectomy Date _____
- Back Surgery Date _____ Type _____
- Bowel Obstruction Date _____
- Breast Biopsy Date _____ Right _____ Left _____
- Breast Cyst Aspiration Date _____ Right _____ Left _____
- Breast Reduction Date _____
- Cataract Surgery Date _____ Right _____ Left _____
- Colon Polyps Date _____
- Colon Surgery Date _____ Type _____
- C-Section Date _____
- Skin Cancer Date _____ Location _____
- Other Surgical History _____ Date _____ Type _____
- Gallbladder Removal Date _____
- Heart Surgery Date _____ Type _____
- Hemorrhoidectomy Date _____
- Hernia Surgery Date _____ Type _____
- Hysterectomy Date _____ Partial _____ Complete _____
- Lung Surgery Date _____ Right _____ Left _____
- Mastectomy Date _____ Right _____ Left _____
- Orthopedic Surgery Date _____ Type _____
- Thyroid Surgery Date _____ Right _____ Left _____
- Tubal Ligation Date _____
- Vascular Surgery Date _____ Type _____

Family Medical History: (Please list any **SIGNIFICANT** illnesses such as cancer, diabetes, heart disease or stroke.)

	Alive	Deceased	Present Health/Cause of Death	Age of Onset
Father	<input type="checkbox"/>	<input type="checkbox"/>		
Mother	<input type="checkbox"/>	<input type="checkbox"/>		
Brothers	<input type="checkbox"/>	<input type="checkbox"/>		
Sisters	<input type="checkbox"/>	<input type="checkbox"/>		

Check illnesses which have occurred in any of your Blood Relatives: Diabetes Heart Disease Cancer Stroke

If checked, please identify relationship (grandmother, grandfather, aunt, or uncle): _____

Family Medical History – CHECK ALL THAT APPLY

DOES NOT APPLY

	MOTHER	SISTER	GRANDMOTHER	OTHER
Breast Pain				
Nipple Discharge				
Lump Removed				
Cyst Drained				
Needle Biopsy				
Fibrocystic Disease				
Breast Abscess				
Breast Cancer				
Ovarian Cancer				
Cervix Cancer				
Colon Cancer				

Signature of Patient/Guardian: X _____ Date _____

SURGERY ASSOCIATES, P.A.

Patient's Request to Release Information to Contact Person(s)

PATIENT NAME _____ **Chart#** _____

Surgery Associates, P.A. will not discuss your personal health information or billing information with anyone except those allowed under federal and state law without your authorization. Please list the name and relationship of those you authorize us to discuss your personal health information and billing information. By signing below you are authorizing the release of your personal health information and billing information to the person(s) named below. It will be your responsibility to notify us if there are any changes to this form including additions or deletions.

Contact Name **Date of Birth** **Relationship** **Phone #**

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Contact Name **Date of Birth** **Relationship** **Phone #**

Contact Name **Date of Birth** **Relationship** **Phone #**

X _____
Signature of Patient (or personal representative such as parent)

Date

Surgery Associates, P.A.

Patient Name _____

Account # _____

- 1. CONSENT FOR TREATMENT:** I request and voluntarily consent for Surgery Associates, P.A. or my treating physician(s) to provide medical and surgical services to me, or to a minor for whom I am responsible.
- 2. RELEASE AND RESPONSIBILITY:** I understand and agree that should I leave Surgery Associates, P.A. without the consent of my physician(s) (against medical advise) that Surgery Associates, P.A. or my physician(s) will not be held liable for such action. Therefore, I hereby relieve Surgery Associates, P.A. or my physician(s) of all responsibility of such action.
- 3. ASSIGNMENT OF BENEFITS:** As a patient, I hereby make the assignment of benefits as set forth:

Medicare and/or Medicaid: I hereby request that payment of authorized Medicare/Medicaid benefits to or on my behalf for services rendered by Surgery Associates, P.A. or my physician(s) shall be made to Surgery Associates, P.A. or my physician(s), and I specifically assign such benefits to Surgery Associates, P.A. and my physician(s). I hereby certify that all information given by me in connection with applying for benefits under Title XVII of the Social Security Act is true, correct and complete in all respects. I understand that payment for certain services not deemed medically necessary by Medicare/Medicaid are not authorized under the Medicare/Medicaid program and that I may be responsible for the entire charge incurred unless other third party coverage is available. I also understand that all deductibles are due unless they have been met within the period specified by Medicare.

INSURANCE: I hereby assign to Surgery Associates, P.A. or my treating physician(s) all rights, benefits and interest under any insurance policy, health plan, worker's compensation or other third party payor liable to me, in consideration for services rendered by Surgery Associates, P.A. or my treating physician(s). I hereby authorize payment directly to Surgery Associates, P.A. or my physician(s) by any insurance company for services received by Surgery Associates, P.A. or my treating physician(s).
- 4. FINANCIAL RESPONSIBILITY AGREEMENT:** I understand that I am financially responsible to Surgery Associates, P.A. or my treating Physician(s) for all charges not covered or paid by insurance. I also understand and agree that all deductibles, coinsurance, co-pays, non-covered charges and other items that are not paid by insurance are due and payable at the time of service based on the best estimates available as determined by Surgery Associates, P.A. or my treating physician(s) and any charges remaining on this account not covered by insurance are payable on demand. If I do not have insurance, I take full responsibility for the payment of all charges incurred on this account. I also agree that in case of default of payment, if this account is placed in the hands of a collection agency or attorney for collection or suit, all reasonable collection fees, reasonable attorney fees, cost and other expenses will be paid by me. I also understand, agree and authorize Surgery Associates, P.A. or my treating physician(s) to verify employment status for the purpose of processing the bill for payment.
- 5. FINANCIAL RESPONSIBILITY FOR DIVORCED PARENTS:** I understand and agree that if I am the parent that brings the child to the office or hospital for treatment by Surgery Associates, P.A. or my treating physician(s), it is my responsibility to pay all charges incurred for services rendered. I further understand that any arrangements made between the two parents concerning payment is the responsibility of the parents not Surgery Associates, P.A. or my treating physician(s).
- 6. NON-CERTIFICATION OF SERVICES:** I hereby agree that as the policyholder/beneficiary of insurance, I am responsible for assuring certification is obtained from the insurance company for the services provided. If certification is not obtained, I further agree that in the event the insurance company deny either or part of the payment on this account, I will pay the account in full upon demand from Surgery Associates, P.A. or my treating physician(s).
- 7. CONSENT FOR RELEASE OF HEALTH INFORMATION FOR BILLING AND PAYMENT PURPOSES:** I hereby consent to the release of my health information (medical records, medical results and an entire copy of my health information) by Surgery Associates, P.A. or my treating physician(s) for the purpose of billing, claims management, medical data processing, eligibility documentation, reimbursement, certification to any insurance company which is necessary for the billing and payment of this account. I understand that these records may contain information concerning my illness and/or treatment to other physicians or facilities that are involved in my medical care. I consent to the release of my entire medical record that may contain treatment notes regarding radiology, pathology including AIDS/HIV test results, genetic testing information, immunization, procedure(s), alcohol and drug abuse records, psychological or psychiatric conditions if any, protected by Federal Confidentiality Rule 42 CFR Park 2, and other common medical records documentation made by the physician, nurse or other ancillary personnel for the entire time I was treated at Surgery Associates, P.A.
- 8. CONSENT FOR RELEASE OF HEALTH INFORMATION FOR TREATMENT PURPOSE:** I hereby consent to the release of my health information (medical records, medical results and an entire copy of my health information) by Surgery Associates, P.A. or my treating physician(s) for the purpose of medical treatment to other physicians or facilities that are involved in my medical care. I understand that these records may contain information concerning my illness and/or treatment to other physicians or facilities that are involved in my medical care. I consent to the release of my complete medical record that may contain treatment notes regarding radiology, pathology including AIDS/HIV test results, genetic testing information, immunization, procedure(s), alcohol and drug abuse records, psychological or psychiatric conditions if any protected by Federal Confidentiality Rule 42 CFR Park 2, and other Common medical records documentation made by the physician, nurse or other ancillary personnel for the entire time I was treated at Surgery Associates, P.A.
- 9. ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:** I hereby acknowledge that I have received and had an opportunity to ask questions concerning Surgery Associates, P.A.'s Notice of Privacy Practices.

This is to certify that I, the undersigned, being the patient or another person legally authorized to act for the patient, have read paragraphs 1-8 of this document, understand its content, and agree to the terms. I understand and agree that a copy of this authorization is as valid as the original. I understand and authorize the release of my personal health information or billing records by facsimile. I agree and understand that this authorization will remain valid until it is terminated by the patient or another person legally authorized to act for the patient.

Signature of Patient _____ Signature of Guardian _____

Date _____ Relationship to Patient _____ Date _____

Witness to Signature _____ Witness To Signature _____

PRIOR EXPRESS CONSENT FORM

Patient # _____

I, _____, "Consumer" understand that it is important for Surgery Associates, P.A., David H. Gilliland, M.D., Raymond J. Orgler, Jr., M.D., Newt P. Harrison, Jr., M.D. and R. Stephen McAdory, M.D. "Service Provider" or an Authorized Entity (as defined below) to be able to communicate with me and have current information about me, my address, my phone number(s), and any other information about me that may assist Service Provider or an Authorized Entity in locating me or communicating with me. In consideration of Service Provider or Authorized Entity providing me services and other good and valuable consideration the receipt and sufficiency of which is hereby acknowledged, Consumer expressly consents and agrees to the terms and conditions contained in this Prior Express Consent Form.

Authorized Entities: The term "Authorized Entities" shall mean the above referenced Service Provider and any related or affiliated health care provider, physician, service provider, independent contractor (including but not limited to billing services) and each of their respective successors, assigns, agents, attorneys, insurers, representatives, employees, officers, shareholders, partners, parents, subsidiaries, affiliated entities, and all agents and representatives of the previously listed persons/entities, and all corporations, persons, or entities in privity with any of the previously listed persons/entities, including any collection agency or debt collector retained or hired by any of the previously listed persons/entities, and all corporations, persons, or entities in privity with any of them. The term Authorized Entities shall also include any person or entity conducting business or providing services relating to health care at the same physical location at which the Service Provider or any of the previously listed persons/entities conducts some or all of its business, and any person or entity Consumer is referred to by Service Provider, and any person or entity who provides health care services related to the services provided by Service Provider.

Communication Consent: I understand that the purpose of this agreement is to authorize the delivery of calls to me, including, but not limited to, using an automatic telephone dialing system or an artificial or prerecorded voice, or calls to a telephone number assigned to a paging service, cellular telephone service, specialized mobile radio service, or other radio common carrier service, or any service for which I am charged for the call (hereinafter "Authorized Communications"). I also understand that my agreement to the terms of this Prior Express Consent Form is not a condition of any Authorized Entity's willingness to provide services to me. To the extent permitted by applicable law, and without limiting any other rights the Authorized Entities may have, I expressly consent and authorize the Authorized Entities to communicate with me for any reason, including reasons related to the services provided by Authorized Entities or services to be provided in the future by the Authorized Entities, including collection of amounts owed for said services, via Authorized Communications at the telephone number or numbers I provide below, or that is provided on my behalf, or any phone number that any Authorized Entity obtains or finds on its own which is not provided by me. In addition, I further expressly consent and authorize the Authorized Entities to communicate with me via SMS text messages, other forms of electronic messages, electronic mail, or other electronic communication sent or directed to me through any medium, no matter how the Authorized Entity obtain such contact information. Any Authorized Entity may communicate with me using any current or future means of communication, even if those means are not now known to the Authorized Entity or Consumer. I authorize any and all of the communication methods described in this paragraph even if I will incur a fee or a cost to receive such communications. I further promise to immediately notify the Authorized Entity if any telephone number or email address or other unique electronic identifier or mode of communication that I provided to any Authorized Entity changes or is no longer used by me. I agree that the consent and authorizations I have provided herein may be revoked only in writing addressed to the Service Provider and any Authorized Entity. Finally, I understand that the Authorized Entities have relied upon my statements contained herein and on my promise to fulfill my obligations contained herein.

I hereby consent and authorize that a photocopy of this authorization may be considered as valid as the original.

This Consent shall ensure to the benefit of and be binding upon my heirs, agents, spouses, executors, administrators, successors, and assigns. I intend for all Authorized Entities to be third party beneficiaries of the consent I have provided herein.

Patient Signature _____ **Guardian Signature** _____

Date _____ **Relationship to Patient** _____ **Date** _____

Witness to Signature _____ **Date** _____

My landline telephone number(s): _____

My cell telephone number(s): _____