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

Mailing Address: _____ City _____ State _____ Zip _____

Social Security #: _____ Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Employer Name & Address _____

Other Parent: _____ Date of Birth: _____
Last First Middle

Mailing Address: _____ City _____ State _____ Zip _____

Social Security #: _____ Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Employer Name & Address _____

Guarantor Information

Guarantor Name: _____ Date of Birth: _____
Last First Middle

Mailing Address: _____ City _____ State _____ Zip _____

Social Security #: _____ Home Phone: _____ Cell Phone: _____

Employer Name & Address _____ Work Phone: _____

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 coy 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** _____

Revised 02/15/2018

PLEASE COMPLETE THE ENTIRE FORM

Patient Name _____ Today's Date _____

Height _____ Weight _____ Age _____ Date of Birth _____ Male _____ Female _____

What problem brings you to our office today? _____ Referring Doctor _____

Primary Care Doctor _____

ALLERGIES

☐ NO KNOWN ALLERGIES

TYPE OF ALLERGY	REACTION YOU HAVE	TYPE OF ALLERGY	REACTION YOU HAVE

MEDICATIONS (INCLUDE OVER-THE-COUNTER MEDICATIONS AND HERBS)

☐ NO MEDICATIONS

NAME OF MEDICATION	DOSAGE	HOW OFTEN	NAME OF MEDICATION	DOSAGE	HOW OFTEN

PAST MEDICAL HISTORY – CHECK ALL THAT APPLY TO YOU

Breast:

☐ Breast Cancer Date _____ Right ____ Left ____
☐ Breast Cyst Date _____ Right ____ Left ____
☐ Breast Feeding ☐ Currently ☐ With any child
☐ Breast Mass Date _____ Right ____ Left ____
☐ Breast Soreness/Pain Date _____ Right ____ Left ____
☐ Fibrocystic Disease Date _____ Right ____ Left ____
☐ Nipple Discharge Date _____ Right ____ Left ____
☐ Other: _____ Date _____

Cardiovascular:

☐ Aneurysm Date _____
☐ Heart Attack Date _____
☐ Heart Disease Date _____
☐ Hypercholesterolemia (High Cholesterol) Date _____
☐ Hypertension (High Blood Pressure) Date _____
☐ Other: _____ Date _____

Endocrine/Hematology:

☐ Anemia Date _____
☐ Bleeding Tendency Date _____
☐ Bruise Easily Date _____
☐ Deep Vein Thrombosis Date _____
☐ Diabetes Date _____ ☐ Type I ☐ Type II
☐ Hepatitis Date _____
☐ Herpes Date _____
☐ HIV Positive Date _____
☐ Leukemia Date _____
☐ Obesity Date _____
☐ Phlebitis Date _____
☐ Sickle Cell Date _____
☐ Thyroid Disease Date _____
☐ Other _____ Date _____

Musculoskeletal:

☐ Arthritis Date _____
☐ Back Injury Date _____
☐ Back Pain Date _____
☐ Disc Problems Date _____
☐ Fibromyalgia Date _____
☐ Gout Date _____
☐ Leg Cramps Date _____
☐ Leg Problems Date _____
☐ Osteoporosis Date _____
☐ Varicose Veins Date _____
☐ Other: _____ Date _____

Neuro/Psychiatric:

☐ Alzheimer's Disease Date _____
☐ Bipolar Disorder Date _____
☐ Depression Date _____
☐ Memory Loss Date _____
☐ Migraines Date _____
☐ Parkinson's Disease Date _____
☐ Seizure Date _____
☐ Stroke Date _____
☐ Other: _____ Date _____

Skin:

☐ Abscess Date _____ Location _____
☐ Melanoma Date _____ Location _____
☐ Skin Cancer Date _____ Location _____
☐ Staph Infections Date _____ Location _____
☐ Other _____ Date _____

Respiratory/Pulmonary:

☐ Asthma Date _____
☐ Bronchitis, Chronic Date _____
☐ Collapsed Lung Date _____
☐ COPD Date _____
☐ Emphysema Date _____
☐ Lung Problems Date _____ Type _____
☐ Pneumonia Date _____
☐ Pulmonary Disease Date _____
☐ Pulmonary Embolism Date _____
☐ Sleep Apnea Date _____
☐ Tuberculosis Date _____
☐ Other _____ Date _____

Gasterointestinal:

- ☐ 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 RefluxDate _____
- ☐ Fecal Impaction Date _____
- ☐ Fecal IncontinenceDate _____
- ☐ Gallbladder Disease Date _____
- ☐ Gallstones Date _____
- ☐ GI Bleeding Date _____
- ☐ Hemorrhoids Date _____
- ☐ Hernia ☐ Bilateral
  - ☐ Left Date _____
  - ☐ Right Date _____
  - ☐ Inguinal Date _____
  - ☐ Hiatal Date _____
  - ☐ Umbillical Date _____
  - ☐ Ventral/Incisional Date _____
- ☐ Irritable Bowel Syndrome Date _____
- ☐ Jaundice Date _____
- ☐ Nausea/Vomitting Date _____
- ☐ Peptic Ulcer Disease Date _____
- ☐ Pilonldal 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 ObstructionDate_____
- ☐ 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_____
- ☐ 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_____

☐ Other Surgical History _____ 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	☐	☐		
Mother	☐	☐		
Brothers	☐	☐		
Sisters	☐	☐		

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 #
Contact Name	Date of Birth	Relationship	Phone #
Contact Name	Date of Birth	Relationship	Phone #
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 entrie 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):_____