Date: _____

PATIENT INFORMATION FORM
(PLEASE PRINT & USE BLACK/BLUE INK)

Patient Name: _____ SS #: _____
First *MI* *Last*

Sex: ☐M ☐F Date of Birth: _____ Marital Status: _____

Spouse Name: _____ Spouse DOB: _____

Race: ☐ Asian ☐Black ☐Caucasian ☐Subcontinent Asian American ☐Native American ☐Hispanic ☐Other

Ethnicity: ☐Latino/Hispanic ☐Not Reported/ Refused ☐Other Primary Language: _____

Employment Status: ☐ Employed ☐ Unemployed ☐Retired ☐ Disabled

Employer: _____ Occupation: _____

Patient Mailing Address: _____
Street *Apt*

_____
City *State* *Zip*

Home Phone: (_____) _____ Cell Phone: (_____) _____ Work Phone: (_____) _____

Which number do you prefer to be contacted at first? ☐Home ☐Cell ☐Work

May we leave a detailed message for you? ☐Home ☐Cell ☐Work

Email Address: _____

How did you hear about us? ☐Physician ☐Friend ☐Website Other: _____

Referring Physician: _____ Phone: _____

Primary Physician *(PCP)*: _____ Phone: _____

PHARMACY

Pharmacy Name: _____ Phone: _____

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

EMERGENCY CONTACT

Contact Name: _____

Relationship: _____ Phone Number: _____

****If the patient is under the age of 18, Emergency Contact should be a Parent or Guardian, except for Emancipated Minors****

Name: _____ Date: _____

PLEASE PROVIDE INSURANCE CARD & ID CARD TO RECEPTIONIST

Primary Insurance:_____

Subscriber's Name: _____ Relationship: _____

Insurance ID #: _____ Date of Birth: _____ Social Security #: _____

Secondary Insurance: _____

Subscriber's Name: _____ Relationship: _____

Insurance ID #: _____ Date of Birth: _____ Social Security #: _____

WORKER'S COMPENSATION

Is your complaint due to injury? ☐NO ☐YES ☐Work ☐Auto ☐Accident Other:_____

IF YOU HAVE ANSWERED YES TO THIS, PLEASE FILL OUT A SEPARATE INFORMATION SHEET

OTHER CURRENT PHYSICIANS

Cardiology: _____ Ph #: _____

Gastroenterology: _____ Ph #: _____

Pulmonary: _____ Ph #: _____

Endocrinology: _____ Ph #: _____

Nephrology: _____ Ph #: _____

Psychology: _____ Ph #: _____

Other: _____ Ph #:_____

Other: _____ Ph #:_____

UNIVERSITY SURGEONS ASSOCIATES, P.C.

PATIENT HEALTH HISTORY

PATIENT'S NAME: _____ **DATE:** _____

REASON FOR TODAY'S VISIT: _____

CURRENT MEDICATIONS: List all the Medications you are currently taking. OR Attach Medication Sheet

NAME OF MEDICATION	DOSAGE	HOW MANY TIMES PER DAY?

ALLERGIES: Please List all the allergies you have below

MEDICATION YOU ARE ALLERGIC TO:	REACTION YOU HAVE:

ARE YOU ALLERGIC TO LATEX?: ☐Yes ☐No ☐Don't Know
ARE YOU ALLERGIC TO IODINE/ CT Dye/ Shell Fish? : ☐Yes ☐No ☐Don't Know

UNIVERSITY SURGEONS ASSOCIATES, P.C.

PATIENT'S NAME: _____ **DATE:** _____

PAST MEDICAL HISTORY (Check all that apply)

- **ENDOCRINE**
- Diabetes
- Thyroid Disease
- High Cholesterol
- **EYES**
- Glaucoma
- Legally Blind
- **CARDIOVASCULAR**
- High Blood Pressure
- Congestive Heart Failure
- Heart Attack _____ Year
- Coronary Heart Disease
- Pacemaker
- Defibrillator
- Cardiac Catheterization
- **RESPIRATORY**
- Asthma
- Emphysema
- Bronchitis
- Pneumonia
- Tuberculosis
- Shortness of Breath
- COPD
- Blood Clot (PE)
- Sleep Apnea
- CPAP
- **GASTROINTESTINAL**
- Diverticulities of Colon
- Colonic Diverticulosis
- GERD
- Ulcerative Colitis
- Crohn's Disease
- Hiatal Hernia
- Irritable Bowel Syndrome
- **GENITOURINARY**
- Dialysis
- Kidney Stone
- Prostate Disorders
- Renal Failure
- End Stage Renal Disease
- Renal Dialysis
- **MUSCULOSKELETAL**
- Arthritis
- Gout
- Lupus
- Fibromyalgia
- **CANCER**
- Breast Cancer
- Skin Cancer
- Hodgkin's Disease
- Prostate Cancer
- Colorectal Cancer
- **NEUROLOGIC**
- Stroke Syndrome
- Seizer Disorder
- Brain Aneurysm
- Neuropathy (weakness hand/feet)
- **HAEMATOLOGIC/LYMPH**
- Clotting Disorder
- Bleeding Disorder
- Anemia
- HIV
- **HEPATIC**
- Hepatitis
- Cirrhosis
- Hepatitis A/ B/ C
- Fatty Liver

PAST SURGICAL HISTORY (Check all that apply)

- **ARTERIAL/VASCULAR SURGERY**
- Aneurysm Repair (AAA)
- Previous Coronary Artery Bypass
- Atherosclerosis of Bypass Graft of the extremities (leg/Bypass)
- Peripheral Stent (Leg/Trunk Stent)
- **BREAST SURGERY**
- Biopsy R/L Year:_____
- Mastectomy R/L Year: _____
- Lumpectomy R/L Year: _____
- Cataract Surgery Year: _____
- Coronary Heart Bypass Year:_____
- Stents Year:_____
- **ABDOMINAL SURGERY** Year: ____
- Appendectomy Year: _____
- Hernia Surgery Year: _____
- Inguinal Right/ Left
- Umbilical Right/Left
- Abdominal Right/ Left
- Hiatal Hernia Surgery
- Colon/ Bowel Surgery Year: ____
- Splenectomy Year: _____
- Hysterectomy Year: _____
- **OTHER**
- Plastic Surgery Year: _____
- Knee Surgery Year:
- Tonsillectomy Year:
- Back Surgery Year:
- **WEIGHT LOSS SURGERY**
- Year: _____Type: _____
- **OTHER SURGERIES NOT LISTED:**

OTHER MEDICAL CONDITIONS NOT LISTED: _____

UNIVERSITY SURGEONS ASSOCIATES, P.C.

PATIENT'S NAME: _____ **DATE:** _____

SOCIAL HISTORY: Please check or complete all that apply

Y	N				
		Current Smoker			
		Former Smoker			
		How long did you smoke	___Days	___Months	___Years
		Year that you Quit Smoking			
		Never Smoked			
		E-Cigarettes (Vaping)			
		Alcohol Use (includes Beer)			
		Caffeine Use			

OCCUPATION: Please check or complete all that apply

Y	N	WORK TYPE	DESCRIPTION
		Job Type	
		Working Full Time	
		Working Part Time	
		Heavy Labor	
		Desk Job	
		Homemaker	
		Retired From Work	
		Unemployed	
		Disabled	
		Reason for Disability	

PLEASE COMPLETE

Y	N	Have you ever had
		Colonoscopy: Year_____
		Mammogram: Year _____
		Pap Smear: Year _____
		Prostate Exam: Year _____
		Flu Vaccine: Date _____
		Pneumococcal Vaccine: Date_____

UNIVERSITY SURGEONS ASSOCIATES, P.C.

PATIENT'S NAME: _____ **DATE:** _____

REVIEW OF SYMPTOMS: Have you experienced any of these symptoms in the last 30 days (Check all that apply)

Y	N	**Systemic Symptoms**
		Weight Change
		Chills
		Fever
		Night Sweats
		Feeling tired or poorly
		Other symptoms:_____
Y	**N**	**Head Symptoms**
		Headache
		Facial Pain
		Sinus Pain
		Other symptoms:_____
Y	**N**	**Eye Symptoms**
		Eyesight problems
		Photophobia
		Eye pain
		Itching of eyes
		Other symptoms:_____
Y	**N**	**Ear Symptoms**
		Earache
		Hearing Loss
		Ringing in the Ears
		Other symptoms:_____
Y	**N**	**Nose Symptoms**
		Nosebleed
		Nasal Discharge
		Other symptoms:_____
Y	**N**	**Neck Symptoms**
		Neck Pain
		Neck stiffness
		Lump/swelling in the neck
		Other symptoms:_____

		Mouth sores
		Bleeding gums
		Hoarsness
		Throat pain
		Other symptoms:_____
Y	**N**	**Breast Symptoms**
		Breast Pain
		Nipple discharge
		Breast Lump
		Other symptoms:_____
Y	**N**	**Cardiovascular Symptoms**
		Chest Pain/discomfort
		Fast Heart Rate
		Palpitations
		Other symptoms:_____
Y	**N**	**Pulmonary Symptoms**
		Shortness of breath
		Cough
		Coughing up blood
		Wheezing
		Other symptoms:_____
Y	**N**	**Gastrointestinal Symptoms**
		Appetite
		Difficulty Swallowing
		Heartburn
		Acid Reflux
		Nausea
		Vomiting
		Abdominal Pain
		Constipation
		Diarrhea
		Black or bloody Stools
		Other symptoms:_____

Y	N	**Genitourinary Symptoms**
		Dysuria
		Increased urinary frequency
		Hematuria
		Genital lesion
		Other symptoms:_____
Y	**N**	**Skin Symptoms**
		Pruritus
		Skin Lesions
		Rashes
		Other symptoms:_____
Y	**N**	**Musculoskeletal Symptoms**
		Joint Pain
		Joint Stiffness
		Muscle Aches
		Other symptoms:_____
Y	**N**	**Neurological Symptoms**
		Dizziness
		Vertigo
		Fainting (Syncope)
		Motor Disturbances
		Sensory Disturbances
		Other symptoms:_____
Y	**N**	**Psychological Symptoms**
		Sleep Disturbances
		Anxiety
		Depression
		Memory Loss
		Other symptoms:_____

ANY OTHER SYMPTOMS NOT LISTED ABOVE: _____

UNIVERSITY SURGEONS ASSOCIATES, P.C.

PATIENT'S NAME: _____ **DATE:** _____

FAMILY HISTORY: Check Boxes if family members have had the following conditions:

SYSTEM	Father	Mother	Brother	Sister	Your Father's Father	Your Mother's Father	Your Father's Mother	Your Mother's Mother
Colon cancer	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Gallbladder disease	☐	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐	☐	☐	☐
Reaction to anesthesia	☐	☐	☐	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐	☐
Alzheimer's disease	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding problems	☐	☐	☐	☐	☐	☐	☐	☐
Cancer (what type?)	☐	☐	☐	☐	☐	☐	☐	☐
Colon polyps	☐	☐	☐	☐	☐	☐	☐	☐
Congestive Heart Failure	☐	☐	☐	☐	☐	☐	☐	☐
COPD (emphysema)	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐
Other Mental disorders	☐	☐	☐	☐	☐	☐	☐	☐
Heart attack	☐	☐	☐	☐	☐	☐	☐	☐
HIV infection	☐	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐	☐	☐	☐
Lung disease	☐	☐	☐	☐	☐	☐	☐	☐
Migraine headaches	☐	☐	☐	☐	☐	☐	☐	☐
Seizure disorder	☐	☐	☐	☐	☐	☐	☐	☐
Substance (drug) abuse	☐	☐	☐	☐	☐	☐	☐	☐
Other medical conditions:	☐	☐	☐	☐	☐	☐	☐	☐

Name: _____

CONSENT TO TREAT

The patient authorizes University Surgeons Associates (USA), to examine and treat the condition as he/she deems appropriate and the patient gives authorization for any procedures to be performed. The patient has the right to informed participation in decisions involving his/her health care. This shall be based on clear & concise explanation of his/her condition and of all proposed treatment procedures. All possible risks and/or side effects as well as the probability of success with such procedures shall be disclosed to the patient by his/her attending provider. The patient will not hold USA responsible for any pre-existing medically diagnosed conditions. The patient has the right to know who is responsible for authorizing and performing any and all treatment procedures. The patient shall not be subjected to any procedure without his/her voluntary, competent, and understanding consent or the consent of his/her legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed. The patient shall be advised if USA proposes to engage in or perform human experimentation for the purpose of research affecting his/her care. The patient has the right to refuse to participate in such research projects.

I have read (or have had read to me) the above information and understand the content.

Signature: _____ Date: _____

CONSENT TO SHARE MEDICAL INFORMATION

Who may we speak with about your medical information?

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(Available in office UPON REQUEST)

I have been given an opportunity to review, ask questions about and understand University Surgeon Associates' (USA) Notice of Privacy Practices for Protected Health Information (Notice). I acknowledge receiving today a copy of the PROVIDER'S notice of privacy policies. I consent to the PROVIDER'S use of protected health information as described in the notice for treatment, payment, or health care operations.

Signature: _____ Date: _____

Name: _____

FINANCIAL RESPONSIBILITY AND CONSENT FORM

Thank you for choosing University Surgeons Associates, PC (USA). The following information is provided regarding your Protected Health Information and Payment for Professional Services

Assumption of Responsibility: I agree that in consideration of services to be rendered, I obligate myself, assume financial responsibility and agree to pay upon demand to above named PROVIDER all charges for such services and incidentals incurred. Should the account be referred to an attorney for collection, I shall pay reasonable attorney fees and collection expenses. Even though insurance may be filed, I understand that all bills are payable upon receipt and that I, not the insurance company is responsible for the payment of all services.

Responsibility for Co-Pay Amounts: I agree to be fully responsible for paying co-pays, deductible and co-insurance of set amounts at the time of physicians visit. Further, I understand that if my co-pay is a percentage, I will be responsible for payment immediately after insurance benefits have paid. This meaning that any bill received once insurance is paid will be due upon receipt. I understand I am responsible for all balances.

Concerns of Identity Theft: I understand that an insurance claim may not be accepted without the use of my social security number.

Assumption of Referrals: I understand that if I have insurance coverage, which requires a referral from a Primary Care Physician (PCP), it must be received in order to receive maximum benefits from the insurance company. I further understand that it is my responsibility to obtain a hardcopy of the referral from my PCP. I will be given an opportunity by the above said provider to obtain a referral or reschedule my appointment. I understand that if I refuse that I am taking full responsibility for payment.

Assignment of Insurance Benefits: I hereby assign direct payment of any hospital insurance benefits, medical insurance benefits including Medicare, Medigap, Major medical benefits, Insurance disability benefits, or injury benefits payable because of liability of a third party or organization, and so forth, payable to or for the above said patient until account is paid in full. If I have no Insurance, I understand I am responsible for 100% of the balances

Responsibility for Non-Covered Charges: I understand that if there are charges that the insurance company does not pay or are not covered then I am billed for these charges. I agree to be responsible for such charges and, I will be responsible for payment immediately after insurance benefits have paid.

Signature: _____ Date: _____

ELECTRONIC COMMUNICATION

We are happy to communicate with you via email and text message during normal business hours. However, prior permission is required by signing below.

Signature: _____ Date: _____

UNIVERSITY SURGEONS ASSOCIATES, P.C.

MEDICAL RECORDS RELEASE

Name: _____ Date of Birth: _____Social Security #: _____

This form must be fully completed before signing

Name doctors you see who we may need to obtain records from or send records to:

Provider: _____ Fax #: _____ Phone #: _____

Provider: _____ Fax #: _____ Phone #: _____

Provider: _____ Fax #: _____ Phone #: _____

Provider: _____ Fax #: _____ Phone #: _____

Provider: _____ Fax #: _____ Phone #: _____

For Dates of Service: _____ or ALL DATES

Purpose of Disclosure: ☐ Treatment ☐ Payment ☐ Billing ☐ Operations OTHER_____

I hereby authorize and request you to Release and/or Request my Medical Records. Information regarding alcohol abuse, substance abuse, HIV/AIDS, or mental health may be disclosed. If you do not wish for us to disclose information regarding alcohol abuse, substance abuse, HIV/AIDS, or mental health please initial here:_____

I understand that information disclosed has the potential for re-disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at University Surgeons Associates (USA). I understand that revoking this authorization stops any further disclosures, but cannot undo any disclosures that have already occurred as requested in the original authorization. I understand authorization for the use or disclosure of the information is voluntary. Federal and state laws permit a fee to be charged for the copying of patient records. I understand that USA may charge a reasonable fee for the supplies, labor and postage involved in copying and mailing this information. USA will either notify or send an invoice if there is an associated fee. I agree that a photo static copy of this authorization shall be considered as effective as the original.

I understand that this authorization will remain active for one year from date of signature

X_____

PATIENT SIGNATURE (Or Personal Representative *) RELATIONSHIP DATE

(* If the patient is represented by another person, please include description of legal authority to act for the individual and if applicable attach a copy of the proof of legal representation. A Durable Power of Attorney for Health Care is sufficient if the patient is unable to make their own health care decisions. POA for managing finances only authorizes the representative to obtain billing/payment records)

Identification Verified by: ☐ Driver License ☐ Other Picture ID: _____ Staff Initials: _____

University Surgeons Associates, Fax: (865) 525-3460
University Bariatric Center, Fax: (865) 305-9168