

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 #: \_\_\_\_\_

**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

PATIENT'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**PAST MEDICAL HISTORY (Check all that apply)**

**PAST SURGICAL HISTORY (Check all that apply)**

<input type="checkbox"/>	<b>ENDOCRINE</b>
<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	High Cholesterol
<input type="checkbox"/>	<b>EYES</b>
<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	Legally Blind
<input type="checkbox"/>	<b>CARDIOVASCULAR</b>
<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Congestive Heart Failure
<input type="checkbox"/>	Heart Attack _____ Year
<input type="checkbox"/>	Coronary Heart Disease
<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	Defibrillator
<input type="checkbox"/>	Cardiac Catheterization
<input type="checkbox"/>	<b>RESPIRATORY</b>
<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	Bronchitis
<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	COPD
<input type="checkbox"/>	Blood Clot (PE)
<input type="checkbox"/>	Sleep Apnea
<input type="checkbox"/>	CPAP
<input type="checkbox"/>	<b>GASTROINTESTINAL</b>
<input type="checkbox"/>	Diverticulities of Colon
<input type="checkbox"/>	Colonic Diverticulosis
<input type="checkbox"/>	GERD
<input type="checkbox"/>	Ulcerative Colitis
<input type="checkbox"/>	Crohn's Disease
<input type="checkbox"/>	Hiatal Hernia
<input type="checkbox"/>	Irritable Bowel Syndrome

<input type="checkbox"/>	<b>GENITOURINARY</b>
<input type="checkbox"/>	Dialysis
<input type="checkbox"/>	Kidney Stone
<input type="checkbox"/>	Prostate Disorders
<input type="checkbox"/>	Renal Failure
<input type="checkbox"/>	End Stage Renal Disease
<input type="checkbox"/>	Renal Dialysis
<input type="checkbox"/>	<b>MUSCULOSKELETAL</b>
<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Gout
<input type="checkbox"/>	Lupus
<input type="checkbox"/>	Fibromyalgia
<input type="checkbox"/>	<b>CANCER</b>
<input type="checkbox"/>	Breast Cancer
<input type="checkbox"/>	Skin Cancer
<input type="checkbox"/>	Hodgkin's Disease
<input type="checkbox"/>	Prostate Cancer
<input type="checkbox"/>	Colorectal Cancer
<input type="checkbox"/>	<b>NEUROLOGIC</b>
<input type="checkbox"/>	Stroke Syndrome
<input type="checkbox"/>	Seizer Disorder
<input type="checkbox"/>	Brain Aneurysm
<input type="checkbox"/>	Neuropathy (weakness hand/feet)
<input type="checkbox"/>	<b>HAEMATOLOGIC/LYMPH</b>
<input type="checkbox"/>	Clotting Disorder
<input type="checkbox"/>	Bleeding Disorder
<input type="checkbox"/>	Anemia
<input type="checkbox"/>	HIV
<input type="checkbox"/>	<b>HEPATIC</b>
<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	Cirrhosis
<input type="checkbox"/>	Hepatitis A/ B/ C
<input type="checkbox"/>	Fatty Liver

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

**OTHER MEDICAL CONDITIONS NOT LISTED:** \_\_\_\_\_

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
		<b>Job Type</b>	
		<b>Working Full Time</b>	
		<b>Working Part Time</b>	
		Heavy Labor	
		Desk Job	
		<b>Homemaker</b>	
		<b>Retired From Work</b>	
		<b>Unemployed</b>	
		<b>Disabled</b>	
		Reason for Disability	

**PLEASE COMPLETE**

Y	N	Have you ever had
		<b>Colonoscopy:</b> Year _____
		<b>Mammogram:</b> Year _____
		<b>Pap Smear:</b> Year _____
		<b>Prostate Exam:</b> Year _____
		<b>Flu Vaccine:</b> Date _____
		<b>Pneumococcal Vaccine:</b> Date _____

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

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

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

ANY OTHER SYMPTOMS NOT LISTED ABOVE: \_\_\_\_\_

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: \_\_\_\_\_



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