PREMIER SURGICAL ASSOCIATES

8-1-2024

PATIENT INFORMATION FORM (PLEASE PRINT AND USE BLACK INK)

Date: _____ Pt#_____

Patient Name *(First, Middle, Last)* _____ **Sex:** M F *(circle one)*

Social Security No. _____ **Date of Birth** _____

Race: *(circle one)* C/W, H/L, B, O**,** Not Reported/Refused **Ethnicity:** *(circle one)* C/W, H/L, B, O, Not Reported/Refused

Language: _____ **Marital Status:** (*circle one)* S, M, D, W, Legally Separated

Employment Status: *(circle one)* Employed , Unemployed, Self Employed, Disabled, Retired, F/T Student, P/T Student

Employer _____ **Occupation** _____

SNF Are you currently in a Skilled Nursing Facility? Y N (circle one) If so, name of **SNF**_____

Patient Mailing Address _____ **City** _____ **State** _____ **Zip** _____

E-mail Address _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

By including your cell phone number, you give Premier consent to call your cell phone for automated appointment reminders

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Referring Physician *(Include Phone No.)* _____

Other *Current* Physicians on Your Care Team *(Include Phone No.)*

Primary Care*(PCP)* _____ **Other** _____

Cardiology _____ **Gastro**_____

Pulmonary _____ **Endocrinology** _____

Nephrology _____ **Dialysis Center** _____

YOUR LOCAL PHARMACY ONLY

Preferred Pharmacy _____ **Phone No.** _____

Pharmacy Address _____ **City** _____ **State** _____ **Zip** _____

EMERGENCY CONTACT INFORMATION

Contact Name *(First, MI, Last)* _____ **Sex:** M F *(circle one)*

Relationship to the Patient:_____ **Language:** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Contact is a Parent/Guardian: Y N *(circle one)* If patient is under the age of 18, Emergency Contact **should** be a Parent or Guardian unless patient is an Emancipated Minor.

INSURANCE INFORMATION

PRIMARY Insurance Company

Ins. Co. Name_____ **Group No.** _____ **Member ID** _____ **Specialist Co-pay** $_____

Primary Insurance Subscriber:_____ **Relationship to the Patient**_____

Subscriber's Social Security No. _____ **Subscriber's Date of Birth** _____

Subscriber's Address *(if different from patient)* _____**City** _____**State** _____**Zip** _____

Subscriber's Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Subscriber's Marital Status: (circle one) S, M, D, W, Legally Separated **Sex:** M F

Employment Status:_____ **Subscriber's Employer** _____

SECONDARY Insurance Company

Ins. Co. Name_____ **Group No.** _____ **Member ID** _____

Secondary Insurance Subscriber:_____ **Relationship to the Patient:**_____

Subscriber's Social Security No. _____ **Subscriber's Date of Birth** _____

Subscriber's Address *(if different from patient)* _____**City** _____**State** _____**Zip** _____

Subscriber's Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Subscriber's Marital Status: (circle one) S, M, D, W, Legally Separated **Sex:** M F

Employment Status:_____ **Subscriber's Employer:**_____

WORKERS COMPENSATION or AUTO INSURANCE INFORMATION

Your Supervisor _____ **Supervisor's Phone No.** _____

Workers Compensation or Auto Insurance Phone No. _____

Claims Address _____ **City** _____ **State** _____ **Zip** _____

Adjuster's Name _____**Adjuster's Phone No.** _____

Claim No. _____ **Approval No.** _____

Date od Injury _____ **Did injury occur at work:** Y N *(circle one)* **Auto Accident:** Y N *(circle one)*

Briefly describe injury or accident _____

Do you have any of the following: *(circle all that apply)* Living Will, Do Not Resuscitate *(DNR)*, Power of Attorney *(POA)*, End of Life Decision, No Cardio-Pulmonary Resuscitation *(CPR)*, None

Patient Name: _____ **Pt#** _____

NOTICE OF PRIVACY PRACTICIES ACKNOWLEDGED

(Available in office UPON REQUEST)

I have been given an opportunity to review, ask questions about and understand Premier Surgical Associates' Notice of Privacy Practices for Protected Health Information *(Notice)*

Patient's Signature X _____**Date**_____

PREMIER SURGICAL ASSOCIATES, PLLC
PLEASE READ

All charges are due at the time of service. If hospitalization or surgery is indicated, we will file your claim directly to your insurance company. Please remember that most insurance companies do not pay the full amount, and therefore, you are responsible for the balance. If there is a problem paying the balance in full, please let us know and we will be happy to work with you.

FINANCIAL RESPONSIBILITY

(Financial Policy is available in office UPON REQUEST)

I understand and commit to the following:

1. I have received a copy of Premier's financial policies and have read and understand these policies.
2. I will pay my co-pay, deductible and co-insurance at the time of service.
3. I will provide the most current insurance information and immediately notify Premier of changes.
4. If surgery is required, all or a portion of my financial responsibility must be paid prior to surgery.
5. I will follow my insurance company's requirements for referrals and pre-authorizations and I understand that if I fail to do so, my insurance benefits will be reduced and I will be responsible for all denied balances.
6. I understand that I am responsible for all balances.
7. If I have no insurance, I have informed Premier and I am responsible for 100% of all balances.
8. A collection fee of 30% will be added to all my accounts that are turned over to collection agencies.

Patient's Signature X _____**Date**_____

INSURANCE AUTHORIZATION AND RELEASE

I request that payment of authorized benefits – including Medicare, and any other government sponsored program, private insurance, and any other health plans – be made to **Premier Surgical Associates, PLLC** for any services furnished by that provider. I authorize any holder of medical information about me to release to those persons or companies presenting a legitimate request for such information needed to determine these benefits or the benefits payable for related services. I authorize **Premier Surgical Associates, PLLC** to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from mu insurance companies. I authorize my insurance companies to give **Premier Surgical Associates, PLLC** any information they require to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

Patient's Signature X _____**Date**_____

MISSED APPOINTMENT POLICY

In order to provide the best care and service to our patients, we ask that you notify us 24 hours in advance to cancel and/or reschedule your office visit, ultrasound or other diagnostic test appointment. A minimum of 30 and up to 90 minutes is set aside for each appointment and your communication and compliance is much appreciated by your physician and supporting staff.
Please be aware that if 24 hour notice is not received a fee of $25 may be charged to your account which must be settled before another appointment is scheduled.
Please call us if you are unable to keep your scheduled appointment. This will provide us an opportunity to reschedule your appointment to a more convenient time and avoid any additional charges on your account.

Patient's Signature X _____ **Date**_____

FOR MEDICARE SUPPLEMENT POLICIES ONLY

ONE-TIME MEDIGAP ASSIGNMENT AND RELEASE

_____ _____

Name **Medicare Number**

_____ _____

Medigap Policy Name **Medigap Policy Number**

I request that payment of the authorized Medigap benefits be made on my behalf to **Premier Surgical Associates, PLLC** for services furnished to me by them. I authorize any holder of medical information about me to release it to:

_____

Name of Policy

Any information needed to determine these benefits to the benefits payable for related services. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

Patient's Signature X _____ **Date**_____

HIPPA Form

Premier Surgical Associates, PLLC

Limited Patient Authorization for Disclosure of Protected Health Information

Please print all information. Form must be signed and dated each year.

Patient Name: _____

SSN (last four digits): _____ **Date of Birth:** _____

Entity Requested to Release Information:

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below.

Who will be authorized to receive information (list the individual/entity who is to receive your PHI)**:**

Individual/Entity Name: _____

Address: _____

Phone: _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:

- ☐ office notes
- ☐ lab results, pathology reports
- ☐ x-rays;
- ☐ financial history report (previous 3 years only).
- ☐ nursing home, home health, hospice, and other physician records
- ☐ record of HIV and communicable disease testing
- ☐ record of mental health or substance abuse treatment
- ☐ Only send the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify): _____

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____

patient or representative signature date

_____ _____

patient or representative signature date

_____ _____

patient or representative signature date

_____ _____

patient or representative signature date

You have the right to receive a copy of signed authorizations upon request.

Updated 2-28-19

Patient History

Patient's Name_____ **DOB:**_____ **AGE:**_____

Date: _____ **REASON FOR VISIT:** _____

updated 8/1/2024

Patient Past Medical History

☐ No Prior Serious Illness

Endocrine
☐Y ☐N Diabetes
☐Y ☐N Thyroid Disorders

Eyes
☐Y ☐N Glaucoma
☐Y ☐N Legally Blind

Cardiovascular
☐Y ☐N High Blood Pressure
☐Y ☐N Congestive Heart Failure
☐Y ☐N Prior Heart Attack
☐Y ☐N Coronary Artery Disease
☐Y ☐N Previous Hospitalization for Cardiac Problem
☐Y ☐N Cardiac Catheterization
☐Y ☐N Non-Healing Wound
☐Y ☐N High Cholesterol

Respiratory
☐Y ☐N Asthma
☐Y ☐N Emphysema
☐Y ☐N Bronchitis
☐Y ☐N Pneumonia

☐Y ☐N Tuberculosis
☐Y ☐N Shortness of Breath
☐Y ☐N Sleep Apnea

Gastrointestinal
☐Y ☐N Diverticulitis of Colon

☐Y ☐N Colonic Diverticulosis
☐Y ☐N GERD
☐Y ☐N Colon Cancer
☐Y ☐N Hepatitis
☐Y ☐N Cirrhosis
☐Y ☐N Ulcerative Colitis
☐Y ☐N Crohn's Disease
☐Y ☐N Hiatal Hernia
☐Y ☐N Irritable Bowel Syndrome

GU
☐Y ☐N Dialysis
☐Y ☐N Kidney Stones
☐Y ☐N Prostate Trouble
☐Y ☐N Renal Failure
☐Y ☐N End Stage Kidney Disease
☐Y ☐N Renal Dialysis

Musculoskeletal
☐Y ☐N Arthritis
☐Y ☐N Gout
☐Y ☐N Lupus
☐Y ☐N Fibromyalgia

Breast
☐Y ☐N Breast Cancer
☐Y ☐N Skin Cancer
☐Y ☐N Scleroderma

Neurologic
☐Y ☐N Stroke Syndrome
☐Y ☐N Seizer Disorder
☐Y ☐N Brain Aneurysm
☐Y ☐N Neuropathy (weakness hands/feet)

Hematologic/Lymph
☐Y ☐N Blood Clots
☐Y ☐N Anemia
☐Y ☐N HIV
☐Y ☐N Hodgkin's Disease
☐Y ☐N Leukemia
☐Y ☐N Lymphoma
☐Y ☐N Clotting Disorders

Social History
☐Y ☐N Alcohol Use
☐Y ☐N Caffeine Use
☐Y ☐N Recreational Drug Use
☐Y ☐N Never Smoked
☐Y ☐N Former Smoker
☐Y ☐N Current Smoker

M=Mother, F=Father, B=Brother, S=Sister, GM/GF=Grandmother/Father

Family History

	M, F, B, S	GM/GF
☐Y ☐N Heart Disease		
☐Y ☐N High Blood Pressure		
☐Y ☐N Diabetes		
☐Y ☐N Stroke		
☐Y ☐N Colon Cancer		
☐Y ☐N Breast Cancer		

Past Surgical History

Arterial Surgery
☐Y ☐N Aneurysm Repair (AAA)
☐Y ☐N Previous Coronary Artery Bypass
☐Y ☐N Atherosclerosis of Bypass Graft of the extremities (Leg/Bypass)
☐Y ☐N Peripheral Stent (Leg/Trunk Stent)

_____ _____
Physician Signature Date

Patient's Name_____ **DOB:**_____

Past Surgical History (cont)

Musculoskeletal Surgery

☐Y ☐N Back Surgery
☐Y ☐N Total Hip Replacement
☐Y ☐N Knee Replacement

☐Y ☐N Rotator Cuff Repair
☐Y ☐N Fracture

Gastrointestinal Surgery

☐Y ☐N Appendectomy
☐Y ☐N Gallbladder Surgery
☐Y ☐N Partial Colectomy (colon resection)
☐Y ☐N Colostomy Bag
☐Y ☐N Ileostomy
☐Y ☐N Hemorrhoidectomy
☐Y ☐N Small Bowell Resection
☐Y ☐N Splenectomy
☐Y ☐N Pancreatectomy
☐Y ☐N Stomach Ulcer Surgery

Head & Neck Surgery

☐Y ☐N Thyroid Surgery
☐Y ☐N Parathyroid Surgery
☐Y ☐N Carotid Surgery or Stent
☐Y ☐N Tonsillectomy/Adenoidectomy

Cardiac/Thoracic Surgery

☐Y ☐N Heart Valve Replacement
☐Y ☐N Heart Bypass (CABG)
☐Y ☐N Cardiac Pacemaker Placement
☐Y ☐N Cardioverter-Defibrillator
☐Y ☐N Heart Stent Placement
☐Y ☐N Lung Surgery

Genitourinary Surgery

☐Y ☐N Nephrectomy
☐Y ☐N Lithotripsy
☐Y ☐N Prostate Surgery

Hernia Surgery

☐Y ☐N Inguinal Hernia Repair (Groin)
☐Y ☐N Umbilical Hernia Repair (Navel)
☐Y ☐N Femoral Hernia Repair
☐Y ☐N Incisional Hernia Repair
☐Y ☐N Ventral Hernia Repair (Abdominal)

Female Surgery

☐Y ☐N Breast Surgery
☐Y ☐N Hysterectomy
☐Y ☐N Tubal Ligation
☐Y ☐N Cesarean Surgery

Other Surgeries

☐Y ☐N Craniotomy
☐Y ☐N Temporal Artery Biopsy
☐Y ☐N Cataract Surgery
☐Y ☐N Bariatric Surgery

Hematologic/Lymph

☐Y ☐N Easy Bleeding
☐Y ☐N Easy Bruising Tendency
☐Y ☐N Swollen Glands in the Neck
☐Y ☐N Groin Lymph Nodes Swelling

Review of Systems (Current Symptoms)

☐Y ☐N Recent Weight Gain of _____ lbs
☐Y ☐N Recent Weight Loss of _____ lbs
☐Y ☐N Fever (as a symptom)
☐Y ☐N Patient believes she is pregnant
☐Y ☐N Patient is currently nursing

Eyes

☐Y ☐N Pain in or Around Eyes
☐Y ☐N Vision Problems

ENMT

☐Y ☐N Loss of Hearing
☐Y ☐N Bleeding Gums

Cardiovascular

☐Y ☐N Chest Pain or Discomfort
☐Y ☐N Heart Rate is Fast
☐Y ☐N Chest Pain when Climbing Stairs

Respiratory

☐Y ☐N Cough
☐Y ☐N Shortness of Breath

Gastrointestinal

☐Y ☐N Black or Bloody Stool
☐Y ☐N Yellow Skin or Eyes (Jaundice)
☐Y ☐N Nausea
☐Y ☐N Vomiting
☐Y ☐N Constipation
☐Y ☐N Diarrhea
☐Y ☐N Abdominal Pain
☐Y ☐N GERD

Genitourinary

☐Y ☐N Blood in Urine
☐Y ☐N Urinary Frequency
☐Y ☐N Pain During Urination

Date of Last Mammogram _____ Never (circle)
Date of Last Colonoscopy _____ Never (circle)

Musculoskeletal

☐Y ☐N Leg Pain with Exercise
☐Y ☐N Localized Soft Tissue Swelling of the Leg

Psychiatric

☐Y ☐N Depression
☐Y ☐N Anxiety
☐Y ☐N Memory Lapses or Loss

Skin/Breast

☐Y ☐N Breast Lump _____ Right _____ Left
☐Y ☐N Breast Pain _____ Right _____ Left
☐Y ☐N Skin Lesions
☐Y ☐N Skin Rash

Neurologic

☐Y ☐N Dizziness

☐Y ☐N Confusion

Vaccines

☐Y ☐N Flu Vaccine
☐Y ☐N Pneumococcal Vaccine
☐Y ☐N Covid Vaccine

_____ _____

Physician Signature Date

Patient's Name_____ DOB:_____

CURRENT MEDICATIONS

NAME OF MEDICATION	DOSAGE (mg, tsp, etc.)	HOW OFTEN DO YOU TAKE THIS MEDICATION

ALLERGIES

MEDICATION YOU ARE ALLERGIC TO:

_____
_____
_____
_____

REACTION YOU HAVE:

_____
_____
_____
_____

☐Y ☐N Allergic to Latex
☐Y ☐N Have you been prescribed a Narcotic/Pain Medication by another MD in the last 30 days?
☐Y ☐N Are you currently enrolled in a Pain Management Clinic
☐Y ☐N Are you currently taking weight loss injections?

HEIGHT: _____ WEIGHT: _____

**PLEASE GIVE THIS FORM TO THE RECEPTIONIST AS SOON AS YOU COMPLETE IT.

_____ _____
Physician Signature Date

Updated 8-1-2024