8-1-2024

PREMIER SURGICAL ASSOCIATES

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 E	Birth
Race: (circle one) C/W, H/L, B, O, Not Repo	rted/Refused Ethnicity: (circle one) C/W, H/L, B, O, Not	t Reported/Refused
Language:	Marital Status: (circle one) S, M, D, W	, Legally Separated
Employment Status: (circle one) Employed	d , Unemployed, Self Employed, Disabled, Retired, F/T St	udent, P/T Student
Employer	Occupation	
	ing Facility? Y N (circle one) If so, name of SNF	
Patient Mailing Address	City	State Zip
E-mail Address		
	Work Phone , you give Premier consent to call your cell phone for	
)	
Referring Physician (Include Phone No.)		
Referring Physician (Include Phone No.) Other)	Phone No.)
Referring Physician (Include Phone No.) Other Primary Care(PCP)) r <u>Current</u> Physicians on Your Care Team (Include	Phone No.)
Referring Physician (Include Phone No.) Other Primary Care(PCP) Cardiology) r <u>Current</u> Physicians on Your Care Team (Include Other	e Phone No.)
Referring Physician (Include Phone No.) Other Primary Care(PCP) Cardiology Pulmonary) r <u>Current</u> Physicians on Your Care Team (Include Other Gastro	Phone No.)
Referring Physician (Include Phone No.) Other Primary Care(PCP) Cardiology Pulmonary) r <u>Current</u> Physicians on Your Care Team (Include Other Gastro Endocrinology	Phone No.)
Referring Physician (Include Phone No.) Other Primary Care(PCP) Cardiology Pulmonary Nephrology) r <u>Current</u> Physicians on Your Care Team (Include Other Gastro Endocrinology Dialysis Center	Phone No.)
Referring Physician (Include Phone No.) Other Primary Care(PCP) Cardiology Pulmonary Nephrology Nephrology Preferred Pharmacy) Physicians on Your Care Team (Include Other Gastro Endocrinology Dialysis Center YOUR LOCAL PHARMACY ONLY	e Phone No.)
Referring Physician (Include Phone No.) Other Primary Care(PCP) Cardiology Pulmonary Nephrology Nephrology Preferred Pharmacy) Physicians on Your Care Team (Include Other Gastro Endocrinology Dialysis Center YOUR LOCAL PHARMACY ONLY Pho	e Phone No.)
Referring Physician (Include Phone No.) Other Primary Care(PCP) Cardiology Pulmonary Nephrology Nephrology Preferred Pharmacy) Physicians on Your Care Team (Include Other Gastro Endocrinology Dialysis Center YOUR LOCAL PHARMACY ONLY Pho	e Phone No.)
Referring Physician (Include Phone No.) Other Primary Care(PCP) Cardiology Cardiology Pulmonary Nephrology Preferred Pharmacy Pharmacy Address) Physicians on Your Care Team (Include Other GastroGastro Endocrinology Dialysis Center YOUR LOCAL PHARMACY ONLY Pho City	e Phone No.)
Referring Physician (Include Phone No.) Other Primary Care(PCP) Cardiology Cardiology Pulmonary Nephrology Preferred Pharmacy Pharmacy Address Contact Name (First, Ml, Last)) Physicians on Your Care Team (Include Other GastroGastro Endocrinology Dialysis Center YOUR LOCAL PHARMACY ONLY Pho CityPho	e Phone No.)

unless patient is an Emancipated Minor.

INSURANCE INFORMATION

PRIMARY Insurance Company

Ins. Co. Name	Group No	Member ID	Specialist Co	o-pay \$
Primary Insurance Subscriber:			-	
Subscriber's Social Security No.	Subscriber's Date of Birth			
Subscriber's Address (if different from pati	ient)	City	State	_Zip
Subscriber's Home Phone	Work Pho	ne	Cell Phone	
Subscriber's Marital Status: (circle one)	S, M, D, W, Legally Separa	ted Sex: M F		
Employment Status:	Subscriber's Employer			
SECONDARY Insurance Company				
Ins. Co. Name	Group No	Member ID		
Secondary Insurance Subscriber:		Relationship t	o the Patient:	
Subscriber's Social Security No.		_ Subscriber's Date of Bi	irth	
Subscriber's Address (if different from pati	ient)	City	State	_Zip
Subscriber's Home Phone	Work Pho	ne	Cell Phone	
Subscriber's Marital Status: (circle one)	S, M, D, W, Legally Separat	ed Sex: M F		
Employment Status:	Subscriber's Employe	er:		
WORKERS CO	OMPENSATION or AU	TO INSURANCE INFO	ORMATION	
Your Supervisor		_ Supervisor's Phone No	0	

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:	YN (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

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

FOR MEDICARE SUPPLEME ONE-TIME MEDIGAP ASSIGNM	
Patient's Signature X	Date
appointment and your communication and compliance is much appreciate Please be aware that if 24 hour notice is not received a fee of \$25 ma before another appointment is scheduled. Please call us if you are unable to keep your scheduled appointment. Th appointment to a more convenient time and avoid any additional charges	y be charged to your account which must be settled s will provide us an opportunity to reschedule your

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 an	d da	ated each year.	
Patient Name:			
SSN (last four digits):		Date of	Birth:
Entity Requested to Release Information:			
Purpose of request (who will be authorized to receiv provide protected health information, about me to			e entity identified above to disclose or
Who will be authorized to receive information (list the	e ind	lividual/entity who is to rea	ceive your PHI):
Individual/Entity Name:			
Address:			
Phone:			
Description of information to be disclosed - I authorize about me to the entity, person, or persons identified			e following protected health information
Entire patient record; or, check only those items	of th	ne record to be disclosed	:
□ office notes		nursing home, home he	alth, hospice, and other physician records
lab results, pathology reports		record of HIV and comr	nunicable disease testing
□ x-rays;		record of mental health	or substance abuse treatment
□ financial history report (previous 3 years only).		Only send the following:	
Purpose of disclosure (please record the purpose of disclosure (please record the purpose of disclosure (please set)) □ Patient Request □ Other (please set)		•	ent request):
 This authorization will expire at the end of the calendar y must renew or submit a new authorization after the expir earlier than the end of the calendar year: You have the right to terminate this authorization at any 	vear c ration	of your last signature below, u a date to continue the autho by submitting a written requ	unless you specify an earlier termination. You rization. Please list the date of expiration if est to our Privacy Manager. Termination of this
authorization will be effective upon written notice, exce		-	
• The practice places no condition to sign this authorization		-	
 We have no control over the person(s) you have listed to information disclosed under this authorization may no lon the responsibility of the practice. 			
patient or representative signature			date
patient or representative signature			date
patient or representative signature			date

date

patient or representative signature

You have the right to receive a copy of signed authorizations upon request. Updated 2-28-19

Patient History

Date

Date: REASON FOR VISIT: Patient Past Medical History No Prior Serious Illness Musculoskeletal Y N Arthritis Endocrine Y N Diabetes Y N Gout Y N Thyroid Disorders Y N Lupus Y N Fibromyalgia Breast Eyes Y N Glaucoma Y N Breast Cancer Y N Legally Blind Y N Skin Cancer Y N Scleroderma Cardiovascular Y N High Blood Pressure **Neurologic** Y N Congestive Heart Failure Y N Prior Heart Attack Y N Coronary Artery Disease Y N Stroke Syndrome Y N Seizer Disorder Y N Brain Aneurysm Y N Previous Hospitalization for Cardiac Problem Y N Neuropathy (weakness hands/feet) Y N Cardiac Catheterization Y N Non-Healing Wound Y N High Cholesterol Hematologic/Lymph Y N Blood Clots Y N Anemia **Respiratory** Y N Asthma Y N Emphysema Y N Hodgkin's Disease Y N Bronchitis Y N Leukemia Y N Lymphoma Y N Clotting Disorders Y N Tuberculosis Y N Shortness of Breath Social History Y N Sleep Apnea Y N Alcohol Use Y N Caffeine Use Y N Recreational Drug Use Gastrointestinal Y N Diverticulitis of Colon Y N Never Smoked Y N Former Smoker Y N Current Smoker Y N Colonic Diverticulosis Y N GERD M=Mother, F=Father, B=Brother, S=Sister, GM/GF=Grandmother/Father M, F, B, S GM/GF **Family History** Y N Colon Cancer Y N Heart Disease Y N Hepatitis Y N High Blood Pressure Y N Cirrhosis Y N Diabetes Y N Ulcerative Colitis Y N Stroke Y N Crohn's Disease Y N Colon Cancer Y N Hiatal Hernia Y N Breast Cancer Y N Irritable Bowel Syndrome Past Surgical History GU Y N Dialysis Y N Kidney Stones Y N Prostate Trouble Y N Renal Failure Arterial Surgery Y N Aneurysm Repair (AAA) Y N Previous Coronary Artery Bypass Y N Atherosclerosis of Bypass Graft of the Y N End Stage Kidney Disease extremities (Leg/Bypass) Y N Renal Dialysis Y N Peripheral Stent (Leg/Trunk Stent)

updated 8/1/2024

Musculoskeletal Surgery Review of Systems [Current Symptoms] Y N Back Surgery Y N Recent Weight Loss of
Y N Total Hip Replacement Y N Recert Weight Loss of
Y N Total Hip Replacement Y N Recert Weight Loss of
Image: Second Surgery Image: Second Surgery
Image: Section Surgery Image: Section Surgery Image: Section Sectin Section Section Section Section Sectin Sec
Y N Rotator Cuff Repair Y N Fracture Eyes Gestrointestinal Surgery Y N Vision Problems Y N Appendectomy Y N Vision Problems Y N Appendectomy (colon resection) Y N Bielding Gums Y N Clostomy Bag Y N Bielding Gums Y N Isotomy Cardiovascular Y N Hemorrholdectomy Y N Chest Pain or Discomfort Y N Small Bowell Resection Y N Heart Rate is Fast Y N Simach Ulcer Surgery Y N Cough Head & Neck Surgery Y N Shortness of Breath Y N Throid Surgery or Stent Y N Ventral Kor Bloody Stool Y N Tonsillectomy/Adenoidectomy Y N Vaniting Y N Cardioverter-Defibrillator Y N Vaniting Y N Cardioverter-Defibrillator Y N Vaniting Y N Cardioverter-Defibrillator Y N Abdominal Pain Y N Cardioverter-Defibrillator Y N Biod in Urination Y N Rephrectomy Y
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Gastrointestinal Surgery Y N Pain in or Around Eyes Y N Appendectomy Y N Vision Problems Y N Gallbladder Surgery ENMT Y N Colstomy (colon resection) Y N Loss of Hearing Y N Colstomy Bag Y N Bleeding Gums Y N Icostomy Bag Y N Reint Pain or Discomfort Y N Small Bowell Resection Y N Heart Rate is Fast Y N Somach Ulcer Surgery Y N Heart Rate is Fast Y N Stomach Ulcer Surgery Y N Cough Head & Neck Surgery Y N Cough Head & Neck Surgery Y N Shortness of Breath Y N Stomach Ulcer Surgery Y N Shortness of Streath Y N Stomach Ulcer Surgery Y N Nousea Condiac/Thoracic Surgery Y N Nousea Condiac/Thoracic Surgery Y N Nomiting Y N Heart Valve Replacement Y N Nomiting Y N Heart Stent Placement Y N Daborinal Pain Y N Cardiac Pacemaker Placement
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Y N Galibladder Surgery EM/T Y N Partial Colectomy (colon resection) Y N Loss of Hearing Y N Colostomy Bag Y N Bleeding Gums Y N Ideostomy Cardiovascular Y N Hemorrhoidectomy Y N Bleeding Gums Y N Heart Rate is Fast Y N Splenectomy Y N Splenectomy Y N Chest Pain or Discomfort Y N Splenectomy Y N Chest Pain or Discomfort Y N Splenectomy Y N Chest Pain or Discomfort Y N Splenectomy Y N Chest Pain or Discomfort Y N Splenectomy Y N Chest Pain or Discomfort Y N Stomach Ulcer Surgery Y N Stomach Ulcer Surgery Y N Stomach Ulcer Surgery Y N Stomach Store Start Y N Parthyroid Surgery Y N Suscer Start Y N Carotid Surgery or Stent Y N Vellow Skin or Eyes (Jaundice) Y N Carotid Surgery or Stent Y N Vellow Skin or Eyes (Jaundice) Y N Carotid Surgery or Stent
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Y N Thyroid Surgery Gastrointestinal Y N Parathyroid Surgery Y N Black or Bloody Stool Y N Carotid Surgery or Stent Y N Black or Bloody Stool Y N Tonsillectomy/Adenoidectomy Y N Vausea Cardiac/Thoracic Surgery Y N Vomiting Y N Heart Valve Replacement Y N Constipation Y N Kausea Y N Vomiting Y N Cardiac Pacemaker Placement Y N Abdominal Pain Y N Cardiac Pacemaker Placement Y N Abdominal Pain Y N Cardiac Pacemaker Placement Y N Abdominal Pain Y N Cardiac Pacemaker Placement Y N Abdominal Pain Y N Cardiac Pacemaker Placement Y N Abdominal Pain Y N Cardiac Pacemaker Placement Y N Bodo in Urine Genitourinary Y N Lang Surgery Y N Bodo in Urine Y N Lung Surgery Y N Blood in Urine Never (circle Y N Nephrectomy Y N Blood in Urinary Frequency Never (circle
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Y N Heart Valve Replacement Y N Constipation Y N Heart Bypass (CABG) Y N Diarrhea Y N Cardiac Pacemaker Placement Y N Abdominal Pain Y N Cardioverter-Defibrillator Y N Abdominal Pain Y N Cardioverter-Defibrillator Y N GERItourinary Y N Heart Stent Placement Genitourinary Y N GERItourinary Y N Heart Stent Placement Genitourinary Y N Blood in Urine Genitourinary Surgery Y N Blood in Urine Y N Replacency Y N N exprestormy Y N Blood in Urine Never (circle) Y N N bephrectomy Y N Pain During Urination Never (circle) Y N N prostate Surgery Date of Last Mammogram Never (circle) Y N Inguinal Hernia Repair (Groin) Y N Localized Soft Tissue Swelling of the Leg Y
Y N Heart Bypass (CABG) Y N Diarrhea Y N Cardiac Pacemaker Placement Y N Abdominal Pain Y N Cardioverter-Defibrillator Y N GERD Y N Heart Stent Placement Y N GeRD Y N Lung Surgery Y N Blood in Urine Genitourinary Surgery Y N Urinary Frequency Y N Nephrectomy Y N Pain During Urination Y N Lithotripsy Date of Last Mammogram Never (circle) Y N Inguinal Hernia Repair (Groin) Y N Leg Pain with Exercise Y N Inguinal Hernia Repair (Navel) Y N Leg Pain with Exercise Y N Incisional Hernia Repair Y N Depression Y N Incisional Hernia Repair (Abdominal) Y N Depression Y N Ventral Hernia Repair (Abdominal) Y N Memory Lapses or Loss Y N Breast Surgery Skin/Breast Y N Memory Lapses or Loss
Y N Cardiac Pacemaker Placement Y N Abdominal Pain Y N Cardioverter-Defibrillator Y N GERD Y N Heart Stent Placement Genitourinary Y N Lung Surgery Y N Blood in Urine Genitourinary Surgery Y N Blood in Urine Genitourinary Surgery Y N N Dephrectomy Y N Nephrectomy Y N Pain During Urination Y N Lithotripsy Date of Last Mammogram Never (circle) Y N Inguinal Hernia Repair (Groin) Y N Leg Pain with Exercise Y N Inguinal Hernia Repair (Groin) Y N Localized Soft Tissue Swelling of the Leg Y N Incisional Hernia Repair Psychiatric Y N Incisional Hernia Repair (Abdominal) Y N Depression Y N Ventral Hernia Repair (Abdominal) Y N Anxiety Female Surgery Y N Memory Lapses or Loss Skin/Breast Skin/Breast
Y N Cardioverter-Defibrillator Y N GERD Y N Heart Stent Placement Genitourinary Y N Lung Surgery Y N Blood in Urine Genitourinary Surgery Y N Urinary Frequency Y N Nephrectomy Y N Pain During Urination Y N Lithotripsy Date of Last Mammogram Never (circle) Y N Prostate Surgery Date of Last Colonoscopy Never (circle) Y N Inguinal Hernia Repair (Groin) Y N Leg Pain with Exercise Y N Umbilical Hernia Repair (Navel) Y N Localized Soft Tissue Swelling of the Leg Y N Incisional Hernia Repair Y N Depression Y N Ventral Hernia Repair (Abdominal) Y N Anxiety Female Surgery Y N Memory Lapses or Loss Y N Breast Surgery Skin/Breast
Y N Heart Stent Placement Y N Lung Surgery Genitourinary Surgery Y N N Y N N Nephrectomy Y N Y N N Lithotripsy Y N P N N Pain During Urination Date of Last Mammogram Never (circle) Y N P N N Prostate Surgery Hernia Surgery Date of Last Colonoscopy Hernia Surgery Never (circle) Y N N Inguinal Hernia Repair (Groin) Y N Y N Y N N Incisional Hernia Repair Y N Y N Y N N Incisional Hernia Repair Y N Y N N Ventral Hernia Repair (Abdominal) Female Surgery Y Y N N Breast Surgery
Y N Lung Surgery Genitourinary Surgery Y N Nephrectomy Y N Notrinary Frequency Y N Nephrectomy Y N Nephrectomy Y N Notrinary Frequency Y N Nephrectomy Y N Notrinary Frequency Y N Prostate Surgery Hernia Surgery Date of Last Colonoscopy Hernia Surgery Musculoskeletal Y N Umbilical Hernia Repair (Groin) Y N Umbilical Hernia Repair (Navel) Y N Incisional Hernia Repair Y N Incisional Hernia Repair Y N Ventral Hernia Repair (Abdominal) Female Surgery Y Y N Breast Surgery
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Y N Prostate Surgery Date of Last Colonoscopy Never (circle Hernia Surgery Musculoskeletal Y N Inguinal Hernia Repair (Groin) Y Y N Umbilical Hernia Repair (Navel) Y Y N N Eemoral Hernia Repair Y Y N Incisional Hernia Repair Y Y N N Incisional Hernia Repair Y Y N N Ventral Hernia Repair Y Y N N Ventral Hernia Repair (Abdominal) Y Female Surgery Y N Y N N Breast Surgery
Hernia Surgery Musculoskeletal Y N Inguinal Hernia Repair (Groin) Y N Leg Pain with Exercise Y N Umbilical Hernia Repair (Navel) Y N Localized Soft Tissue Swelling of the Leg Y N Femoral Hernia Repair Psychiatric Y N Incisional Hernia Repair Y N Depression Y N Ventral Hernia Repair (Abdominal) Y N Anxiety Female Surgery Y N Memory Lapses or Loss Y N Breast Surgery Skin/Breast
Y N Inguinal Hernia Repair (Groin) Y N Leg Pain with Exercise Y N Umbilical Hernia Repair (Navel) Y N Localized Soft Tissue Swelling of the Leg Y N Femoral Hernia Repair Psychiatric Y N Incisional Hernia Repair Y N Depression Y N Ventral Hernia Repair (Abdominal) Y N Anxiety Female Surgery Y N Memory Lapses or Loss Y N Breast Surgery Skin/Breast
Y N Umbilical Hernia Repair (Navel) Y N Localized Soft Tissue Swelling of the Leg Y N Femoral Hernia Repair Psychiatric Y N Incisional Hernia Repair Y N Depression Y N Ventral Hernia Repair (Abdominal) Y N Anxiety Female Surgery Y N Memory Lapses or Loss Y N Breast Surgery Skin/Breast
Y N Femoral Hernia Repair Psychiatric Y N Incisional Hernia Repair Y N Depression Y N Ventral Hernia Repair (Abdominal) Y N Anxiety Female Surgery Y N Memory Lapses or Loss Y N Breast Surgery Skin/Breast
Y N Incisional Hernia Repair Y N Depression Y N Ventral Hernia Repair (Abdominal) Y N Anxiety Female Surgery Y N Memory Lapses or Loss Y N Breast Surgery Skin/Breast
Y N Ventral Hernia Repair (Abdominal) Y N Anxiety Female Surgery Y N Memory Lapses or Loss Y N Breast Surgery Skin/Breast
Female Surgery Y N Memory Lapses or Loss Y N Breast Surgery Skin/Breast
Y N Breast Surgery Skin/Breast
$Y \square N$ Hysterectomy $Y \square N$ Breast Lump Right Left $X \square N$ Tybel light on the sector of th
V Tubel lightion
Y N N Skin Lesions
Other Surgeries
Y N Craniotomy Neurologic
Y N Y N Dizziness
Y N Cataract Surgery Y N Bariatric Surgery Y N Confusion
Hematologic/Lymph Vaccines
Y N Flue Y N Flue Y N
\square Y \square N Easy Bruising Tendency \square Y \square N Pneumococcal Vaccine
Y N Easy Bruising Tendency Y N Pneumococcal Vaccine Y N Swollen Glands in the Neck Y N Covid Vaccine
\square Y \square N Groin Lymph Nodes Swelling

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.