

# 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 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\*\**

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 \_\_\_\_\_

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

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## 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 of 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# \_\_\_\_\_

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**NOTICE OF PRIVACY PRACTICES 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 my 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 \_\_\_\_\_

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### 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 \_\_\_\_\_

# 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:

- |  |  |
|--|--|
| <input type="checkbox"/> office notes                                      | <input type="checkbox"/> nursing home, home health, hospice, and other physician records |
| <input type="checkbox"/> lab results, pathology reports                    | <input type="checkbox"/> record of HIV and communicable disease testing                  |
| <input type="checkbox"/> x-rays;   | <input type="checkbox"/> record of mental health or substance abuse treatment            |
| <input type="checkbox"/> financial history report (previous 3 years only). | <input type="checkbox"/> 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'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_  
 DATE: \_\_\_\_\_ REASON FOR VISIT: \_\_\_\_\_

**Patient's Past Medical History**

No prior serious illness

**Endocrine**

- Y  N  Diabetes
- Y  N  Thyroid Disease
- Y  N  High Cholesterol

**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 Heart Disease
- Y  N  Previous Hospitalization for Cardiac problem
- Y  N  Cardiac Catheterization
- Y  N  Non Healing Wound

**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

**Genitourinary**

- Y  N  Dialysis
- Y  N  Kidney Stones
- Y  N  Prostate Disorders
- Y  N  Renal Failure
- Y  N  End Stage Renal 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  Seizure 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

**Social History**

- Y  N  Alcohol Use
- Y  N  Caffeine Use
- Y  N  Recreational Drug Use

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

**Family History**

	M, F, B, S	GM/GF
Y <input type="checkbox"/> N <input type="checkbox"/> Heart Disease		
Y <input type="checkbox"/> N <input type="checkbox"/> High Blood Pressure		
Y <input type="checkbox"/> N <input type="checkbox"/> Diabetes		
Y <input type="checkbox"/> N <input type="checkbox"/> Stroke Syndrome		
Y <input type="checkbox"/> N <input type="checkbox"/> Colon Cancer		
Y <input type="checkbox"/> N <input type="checkbox"/> 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's 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
- Y  N  Ileostomy
- Y  N  Hemorrhoidectomy
- Y  N  Small Bowel 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

**Review of Systems (Current Symptoms)**

**Constitutional**

- Y  N  Recent Weight Gain of \_\_\_\_\_ lbs
- Y  N  Recent Weight Loss of \_\_\_\_\_ lbs
- Y  N  Fever (as a symptom)

**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 Stools
- 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

Physician's signature \_\_\_\_\_

Date \_\_\_\_\_

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

DOB: \_\_\_\_\_

***Hematologic/Lymph***

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

***Other***

- Y  N  Patient believes she is pregnant
- Y  N  Periods of not breathing while asleep
- \_\_\_ Never Smoked \_\_\_ Former Smoker \_\_\_ Current Smoker

- Y  N  Flu Vaccine
- Y  N  Pneumococcal Vaccine
- Y  N  PTCA, if so what year \_\_\_\_\_

**CURRENT MEDICATIONS**

NAME OF MEDICATION	DOSAGE (mg, tsp, etc)	HOW MANY TIMES PER DAY

**ALLERGIES**

MEDICATION YOU ARE ALLERGIC TO:	REACTION YOU HAVE:

- Y  N  ALLEGRIC TO LATEX
- Y  N  HAVE YOU BEEN PRESCRIBED A NARCOTIC/PAIN MEDICATION BY ANOTHER MD IN THE LAST 30 DAYS?
- Y  N  ARE YOU CURRNETLY ENROLLED IN A PAIN MANAGEMENT CLINIC?

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

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

\_\_\_\_\_  
Physician's signature

\_\_\_\_\_  
Date