

SCA

SURGICAL CARE ASSOCIATES

4003 KRESGE WAY, SUITE 100, LOUISVILLE, KENTUCKY 40207 502-897-5139

Patient Information

Name _____ Home Phone _____
Address _____ Other Phone _____
City _____ Date of Birth _____ Age _____
State _____ Zip Code _____ Social Security No. _____
Sex M F Marital Status _____ Employer _____
Referring Physician _____ Employer Address _____
Primary Care Physician _____ Employer Phone No. _____

Responsible Party If Different From Patient

Name _____ Home Phone _____
Address _____ Work Phone _____
City _____ Date of Birth _____
State _____ Zip Code _____ Social Security No. _____
Relation to Patient _____
Employer _____ Address _____

Emergency Contact Information

Person to Contact in Case of Emergency _____
Phone No. _____ Relation to Patient _____

Insurance Information

Is this claim: Workman's Comp or an Accident?
Plan name: _____ Are you the primary cardholder? Yes No
Cardholders date of birth: _____ If not, who is the primary cardholder? _____
Relationship to patient: _____

Insurance cards are required at the time of visit. We will be happy to copy your card or if you prefer, you can bring a copy (front and back). If you bring a copy, please make sure all numbers and addresses are legible.

I hereby authorize the release of any medical information necessary to process my insurance.

Signature _____ Date _____

I hereby authorize payment directly to the provider of service and I understand that I am financially responsible for my copays, coinsurance and deductibles as well as any services not deemed medically necessary by my insurance company.

Signature _____ Date _____

**Surgical Care Associates
Personal Health Information**

Below is a worksheet which details your personal health information. Be as complete as possible.

Name _____ DOB _____ Age _____ Requesting Physician _____ Primary Care _____	Other physicians _____ _____ _____ _____
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Reason for Visit: _____

List Your Medical Illnesses

1. _____
2. _____
3. _____
4. _____

Past Operations, angiograms, angioplasties, and cardiac cath: (Please include dates)

Allergies: _____

Current Medications: (If too many use back or bring separate list) (Include medication, strength, frequency) _____ _____ _____ _____ _____ _____	Social History Ht _____ Wt _____ Who do you live with _____ Occupation: _____ Do you smoke _____ How much _____ Do you use alcohol _____ How much _____ Illicit Drug Use _____ Exercise _____
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Family History <table style="width:100%; border: none;"> <tr> <td style="width:70%;"></td> <td style="text-align: right; width:30%;">relation</td> </tr> <tr> <td>Heart Disease</td> <td>_____</td> </tr> <tr> <td>Aortic Aneurysm</td> <td>_____</td> </tr> <tr> <td>Diabetes</td> <td>_____</td> </tr> <tr> <td>Stroke</td> <td>_____</td> </tr> <tr> <td>Cancer</td> <td>_____</td> </tr> <tr> <td>Blood Clots</td> <td>_____</td> </tr> <tr> <td>Bleeding</td> <td>_____</td> </tr> <tr> <td>Other</td> <td>_____</td> </tr> </table>		relation	Heart Disease	_____	Aortic Aneurysm	_____	Diabetes	_____	Stroke	_____	Cancer	_____	Blood Clots	_____	Bleeding	_____	Other	_____	Father: Age _____ If deceased, cause of death _____ _____ Mother: Age _____ If deceased, cause of death _____ _____ Spouse: Age _____ If deceased, cause of death _____ _____	Immunization History <table style="width:100%; border: none;"> <tr> <td style="width:70%;"></td> <td style="text-align: right; width:30%;">Date</td> </tr> <tr> <td>Influenza</td> <td>_____</td> </tr> <tr> <td>Pneumonia</td> <td>_____</td> </tr> <tr> <td>Hepatitis</td> <td>_____</td> </tr> <tr> <td>Tetanus</td> <td>_____</td> </tr> <tr> <td></td> <td>_____</td> </tr> <tr> <td></td> <td>_____</td> </tr> </table>		Date	Influenza	_____	Pneumonia	_____	Hepatitis	_____	Tetanus	_____		_____		_____
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Signature _____ date _____

System Review

Circle any symptoms you experience

General:

Weight change
Fatigue
Weakness
Fever
Chills
Loss of appetite
Feeling bad

Skin:

Dryness
Rash
Itching
Breaking out
Skin lesions
Change in mole
Easy bruising
Nonhealing sores

Eyes:

Watering
Dryness
Blurred vision
Loss of vision
Pain
Double vision

Head Ears Nose Throat:

Hair loss
Hearing loss
Ear Pain
Ringing in ears
Nose bleeds
Sinus congestion
Bleeding gums
Hoarseness
Lesions of the mouth

Heart:

Previous cardiac cath
Chest Pain
Chest Heaviness
Skipped Heart Beats
Palpitations
Fatigue on exertion
Ankle swelling
Shortness of breath

Chest:

Cough
Sputum production
Wheezing
Shortness of breath
Chest pain
Coughing up blood

Vascular:

Walking Problems
Leg pain
Foot pain
Leg ulcer
Foot ulcer
Nonhealing ulcer
Leg swelling
Arm pain
Arm numbness
Phlebitis
Aneurysms

Gastrointestinal:

Abdominal Pain
Indigestion
Trouble swallowing
Vomiting
Diarrhea
Constipation
Change in bowel habits
Gallbladder trouble
Jaundice
Hepatitis
Cirrhosis of the Liver
Black bowel movements
Blood in bowel movements

Genitourinary (male):

Burning with urination
Urination with frequency
Impotence
Incontinence
Frequent urination at night
Inadequate urinary stream
Blood in urine
Passage of stone
Testicular pain

Genitourinary (female):

Burning with urination
Urination frequency
Incontinence
Blood in urine
Frequent urination at night
Passage of stone
Pelvic pain
Vaginal discharge
Irregular menses
Menopause
Vaginal bleed

Sexual:

Impotence
Sexually transmitted disease

Breast:

Lumps
Nipple Discharge
Skin changes
Tenderness

Musculoskeletal:

Joint pain
Joint swelling
Muscle pain
Walking problems
Stiffness

Neurological:

Dizziness
Blurred vision
Blackouts
Seizures
Paralysis
Numbness
Tingling of hands or feet
Tremors
Loss of use of arms/legs
Speech problems
Memory difficulty
Headaches
Loss of vision
Transient ischemic attack

Endocrine:

Weight change
Excessive
Thirst
Excessive urination
Bone pain
Temperature intolerance
Changes in heart rate
Sweating
Weakness

Blood and Lymphatics:

Bleeding tendency
Easy Bruising
Anemia
Excessive clotting
Groin swelling
Neck Swelling

Psychiatric:

Unhappy
Mood swings
Crying spells
Poor concentration
Anxious
Insomnia

Signature _____ date _____