Surgical Care Associates

PATIENT INFORMATION

NAME ____________________ HOME PHONE ____________________

ADDRESS ____________________ OTHER PHONE ____________________

CITY ____________________ DATE OF BIRTH __________ AGE ______

STATE __________ ZIP ______ SSN ____________________

E-MAIL ____________________ EMPLOYMENT STATUS ____________________

MARITAL STATUS ____________________ EMPLOYER ____________________

GENDER M ______ F ______ EMP ADDRESS ____________________

EMP PHONE # ____________________

Test results and information regarding my health can be released to the following:

NAME ____________________ PHONE ____________________

NAME ____________________ PHONE ____________________

NAME ____________________ PHONE ____________________

NAME __________ __________ PHONE ____________________

NAME ____________________ PHONE ____________________

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME ____________________ PHONE ____________________

RELATION TO PATIENT ____________________

INSURANCE INFORMATION

PLAN NAME: ____________________

ARE YOU THE PRIMARY CARDHOLER? YES ______ NO ______

IF NOT, WHO IS THE PRIMARY CARDHOLDER: ____________________

CARDHOLDERS DATE OF BIRTH: ____________________

RELATION TO PATIENT ____________________

IS THIS CLAIM WORKERS COMP ______ OR AN ACCIDENT ____________________

Please give insurance card(s) to the receptionist to copy. If you do not have them with you today, you will be responsible for charges related to today’s visit including outpatient testing and/or surgery unless you fax/mail or bring a copy of your card (front and back) at least 3 days prior to any scheduled procedure.

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

Date: Signature:

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

Date: Signature:

HERITAGE

RACE

______ ASIAN

______ BLACK or AFRICAN AMERICAN

______ HISPANIC or LATINO

______ NATIVE HAWAIIAN OR OTHER PACIFIC ISLAND

______ WHITE or CAUCASIAN

______ AMERICNAN INDIAN or ALASKIA NATIVE

ETHNICITY ______ HISPANIC or LATINO ______ NON-HISPANIC or NON-LATINO

LANGUAGE

______ ENGLISH ______ FRENCH ______ ITALIAN

______ JAPANESE ______ KOREAN ______ PORTUGUESE

______ RUSSIAN ______ SPANISH ______ CHINESE

DO YOU NEED AN INTERPRETER? ____________________

Signature ____________________ date __________

Surgical Care Associates

Patient Name____Age________

Personal Health Information

Below is a worksheet which details your personal health information. Be as complete as possible. Do not worry about every area. We will help.

OTHER PHYSICIANS with whom we will correspond

Requesting Physician___________________________
Primary Care______________________

Other Physicians

_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________

Reason for Visit: ____

____

Past Medical History

Have you experienced any condition listed below: if yes, please check; may explain

___Coronary Artery Disease ____
___Kidney failure____
___Chronic lung disease____
___Stroke____
___Sleep Apnea_____________________Use or prescribed CPAP?___________________
___Excessive bleeding from operation____
___Blood clots, Deep Vein thrombosis, Pulmonary emboli___________________________
___Are you hearing impaired?______________Do you need an interpreter?_____________
___Are you diabetic? ___No ___Yes ___Insulin ___Noninsulin

Please list your other medical conditions

____
____
____
____

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

____
____
____
____
____
____
____
____

Signature ________________________ date____________

Surgical Care Associates

Patient Name:____Age:_______

Allergies

____

____

Do you have latex allergy ________________________

Current Medications: (If too many use back or bring separate list, Include medication, strength, frequency)

____

____

____

____

____

____

____

____

____

____

Do you use Aspirin? Yes____ No_____ Do you use Coumadin____________

Pharmacy Information

Pharmacy name ____________________ Address ____________________________

Phone

Social History

Ht___________ Wt____________

Who do you live with _________________

Occupation:____________________________

Do you use alcohol______________________

How much_________________________

Illicit Drug Use__________________________

Smoking

___Current every day smoker

___Current some day smoker

___Former smoker

___Never smoked

Exercise__________________________________

Family History

Indicate if a family member has experienced these conditions:

Heart Disease____________________________

Aortic Aneurysm__________________________

Stroke____________________________________

Cancer____________________________________

Blood clots________________________________

Bleeding tendency__________________________

Other_____________________________________

Father: Age_______

If deceased, cause of death____________________________________

Mother: Age______

If deceased, cause of death____________________________________

Spouse: Age _______

If deceased, cause of death____________________________________

Immunization History (indicate date last vaccinated)

Influenza _________ Hepatitis _________

Pneumonia _________ Tetanus _________

Signature __________________________ date_____________