

Patient

Responsible Party (if patient is minor)

(All New Patients)															
Last Name		First Name		Last Name		First Name		Relationship to Patient							
Address				Address											
City		State		Zip		City		State		Zip					
Primary Phone		Phone 2		Phone 3		Primary Phone		Phone 2		Phone 3					
Email Address				Email Address											
Social Security Number		Date of Birth (MM-DD-YY)		Age		Sex		Social Security Number		Date of Birth (MM-DD-YY)		Age		Sex	
Marital Status		Maiden Name		Marital Status		Maiden Name									
Patient Employment/Student Status <input type="checkbox"/> Employed <input type="checkbox"/> Student <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time				Guarantor Employment/Student Status <input type="checkbox"/> Employed <input type="checkbox"/> Student <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time											
Occupation				Occupation											
Employer or School		Phone Number		Employer or School		Phone Number									
Emergency Contact Name				Phone				Relationship							

Referring Doctor

Primary Care Physician

Last Name		First Name		Primary Care Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No		Last Name		First Name	
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Insurance Information

Primary Insurance		Secondary Insurance		Other Insurance	
Insurance Company	Phone	Insurance Company	Phone	Insurance Company	Phone
Subscriber's Name		Subscriber's Name		Subscriber's Name	
Subscriber's Birthdate		Subscriber's Birthdate		Subscriber's Birthdate	
Social Security Number		Social Security Number		Social Security Number	
Insurance ID (Policy No.)	Group/FECA #	Insurance ID (Policy No.)	Group/FECA #	Insurance ID (Policy No.)	Group/FECA #

Authorization to Release Medical Information and Benefits:

I hereby authorize Southwest Surgical Associates (SWSA) to release any medical information that may be necessary for either medical care or in processing insurance for financial benefit. While SWSA will make a reasonable effort to collect payment from my insurance company (where applicable), I understand that I am responsible for payment of the services rendered, and furthermore agree to pay attorney fees, court costs, collection and filing fees, including charges or commission up to fifty percent that may be assessed to us by any collection agency retained to pursue this matter. I further agree to pay interest at the rate of 1.5% per month (18% per year) on any amount sent to collections. I understand and agree that I am financially responsible for all deductible amounts, co-insurance, non-covered services or services deemed as "non-medically necessary" by my third party insurance carrier.

Patient/Guarantor Signature: _____ Date: _____

(Medicare Patients Only)

<p>Medicare Patient Agreement</p> <p>I request that payment of authorized Medicare benefits be made on my behalf to Southwest Surgical Associates for any service rendered to me by such provider. This authorization will remain in effect until I choose to revoke it in writing.</p> <p>Signature: _____ Date: _____</p>
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Patient History Questionnaire

Patient Name: _____ DOB: _____

List of Symptoms: _____

Allergies: _____

Past Hospitalizations/ Surgeries/ Injuries and Approximate Dates: _____

Family History: Please list any medical problems that have existed within your family.

Father: _____

Mother: _____

Siblings: _____

Other: _____

Social History:

Marital Status: Single Married Separated Divorced Widowed

Tobacco Use: Never Quit/ When _____ Current smoker / Packs per day _____

Alcohol Use: Never Rarely Moderately Daily How much? _____

Drug Use: Never Type & Frequency _____

Patient History Detail

Patient Name: _____ DOB: _____

Please circle Yes (Y) or No (N) if you have or have had any of the following problems:

Constitutional

Y N Good general health
Y N Recent weight Change
Y N Night sweats / Fevers
Y N Fatigue

Ears/Nose/Mouth/Throat

Y N Hearing loss or ringing
Y N Sinus problems
Y N Nose bleeds
Y N Sore throat/ voice change

Eyes

Y N Wear glasses/ contacts
Y N Blurred/ double vision
Y N Eye disease or injury
Y N Glaucoma

Cardiovascular

Y N Chest
Y N Palpitations
Y N Stroke
Y N Heart trouble
Y N Swelling in hands/feet
Y N High blood pressure

Respiratory

Y N Shortness of breath
Y N Cough
Y N Wheezing/ Asthma
Y N Coughing up blood

Gastrointestinal

Y N Nausea/ Vomiting
Y N Abdominal pain
Y N Rectal bleeding
Y N Bowel problems

Musculoskeletal

Y N Muscle pain or cramps
Y N Stiffness / swelling joints
Y N Joint pain
Y N Trouble walking

Neurological

Y N Frequent headaches
Y N Paralysis or tremors
Y N Convulsions / Seizures
Y N Numbness / Tingling

Integumentary (Skin/Breast)

Y N Change in hair or nails
Y N Rashes or itching
Y N Breast Lump
Y N Breast pain / discharge

Endocrine

Y N Excessive thirst / urination
Y N Thyroid disease
Y N Hormone problem
Y N Diabetes

Hematologic/Lymphatic

Y N Bruise easily
Y N Slow to heal
Y N Enlarged glands
Y N Bleeding problems
Y N HIV / AIDS
Y N Hepatitis

Allergic/Immunologic

Y N Allergies
Y N Aspirin allergies
Y N Antibiotic allergies

Genitourinary – Male only

Y N Blood in urine
Y N Kidney stones
Y N Sexual problems
Y N Testicle pain

Genitourinary – Female only

Y N Blood in urine
Y N Kidney stones
Y N Sexual problems
Y N Menstrual Problems

Psychiatric

Y N Insomnia
Y N Confusion / memory
Y N Depression
Y N Anxiety

Cancer (what type): _____

Other problems: _____

Patient Statement: To the best of my knowledge, the above information is accurate and complete.

Signed: _____

Physician Statement: I have reviewed the questionnaire with the patient.

Signed: _____ Date: _____

Southwest Surgical Associates

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of Southwest Surgical Associates Notice of Privacy Practices and had a chance to ask questions regarding how my medical information will be used. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

Name of Patient (please print)

Signature of Patient or Representative
(Required if patient is a minor or unable to sign)

Date

Relationship of Representative to Patient

Patient was given our privacy notice but opted not to sign.

Information Release

If you would like to authorize Southwest Surgical Associates to release any of your medical information including test and lab results, prescriptions, and treatment plans to individuals other than yourself (excluding your physicians) please list them below.

Name

Relationship to patient

