

SURGICAL ASSOCIATES, L.L.P.
A PARTNERSHIP OF PROFESSIONAL CORPORATIONS

NAME OF PATIENT:

LIST ANY PREVIOUS

NAMES: _____

ADDRESS:

STREET	APT#	CITY	STATE	ZIP
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TELEPHONE#: _____ **SOC.SEC. #:** _____ **AGE:** _____

DATE OF BIRTH: _____ PLEASE CIRCLE **MALE** **FEMALE** **MARITAL STATUS:** **M** **S** **D** **W** **SEP**

EMPLOYER: _____ **NAME OF SPOUSE:**

OCCUPATION: _____ **SPOUSE'S EMPLOYER:**

ADDRESS: _____ **ADDRESS:**

TELEPHONE: _____

TELEPHONE: _____

EMERGENCY CONTACT: (NOT AT SAME ADDRESS) _____

TELEPHONE: _____ **RELATIONSHIP TO PATIENT** _____

IF PATIENT IS A CHILD OR STUDENT, PLEASE LIST PARENT'S NAME, ADDRESS & TELEPHONE:

MOTHER: _____ **ADDRESS:**

TELEPHONE: _____

FATHER: _____ **ADDRESS:**

FAMILY PHYSICIAN: _____ **REFERRING PHYSICIAN:**

TELEPHONE #: _____

ADDRESS: _____

BILLING INFORMATION

RESPONSIBLE PARTY (if same as patient, skip to insurance section):

RELATIONSHIP TO PATIENT: _____ SOC.SEC.#: _____

ADDRESS: _____

TELEPHONE: _____ **THIS OFFICE DOES ACCEPT VISA & MASTERCARD**

INSURANCE INFORMATION

INSURANCE:
Please present your insurance cards at reception desk. This will assist us to accurately file your

PRIMARY: _____

SECONDARY: _____

WORKER'S COMP: _____ **INJURY DATE:** _____

EMPLOYER: _____ **OCCUPATION:** _____

"I, the undersigned, authorize payment of medical benefits to Surgical Associates for any services furnished to me by the physicians. I understand that I am financially responsible for any amount not covered by my insurance. I also authorize you to release to my insurance company and/or the Health Care Financing and Administration and its agents, any information concerning health care advice, treatment or supplies provided to me, either to determine these benefits or benefits payable for related service. This information will be used for the purpose of evaluation and administering claims of benefits. A photocopy is as valid as the original.

SIGNATURE: _____

DATE: _____

(SEE OTHER SIDE)

PATIENT INFORMATION

PHARMACY PREFERENCE:

PAST MEDICAL HISTORY

PREVIOUS SURGERIES

SURGERY: _____ **DATE:** _____ **SURGEON:** _____ **HOSPITAL:** _____

HABITS

SMOKING: YES NO **ALCOHOL:** YES NO

PACKS PER DAY: _____

YEARS SMOKED: _____ **QUIT DATE:** _____



FAMILY HISTORY

LIST MEDICAL CONDITIONS PRESENT, OR IF DECEASED, LIST AGE & CAUSE OF DEATH.
IF CANCER HISTORY, PLEASE LIST TYPE, AND IN WHOM.

MOTHER: _____ **SIBLINGS:** _____

FATHER: _____ **CHILDREN:** _____

REVIEW OF SYMPTOMS

PLEASE CHECK THE SYMPTOMS WHICH YOU CURRENTLY HAVE OR HAVE HAD, AND INCLUDE THE DATE, IF KNOWN.

NEUROLOGIC

- DIZZINESS
- TEMPORARY VISION LOSS
- CONFUSION
- HEADACHES
- PARALYSIS
- NUMBNESS IN HANDS/FEET
- WEAKNESS
- SEIZURES

HEMATOLOGY, IMMUNOLGY & INFECTION

- CHILLS
- FEVER
- EASY BRUISING
- NIGHT SWEATS
- FATIGUE
- WEIGHT LOSS
- SWOLLEN LYMPH NODES

EYES, EARS, NOSE & THROAT

- HARD OF HEARING
- NOSEBLEEDS
- SINUS PROBLEMS
- BLEEDING GUMS
- CATARACTS
- NEARSIGHTED/FARSIGHTED

CANCER

TYPE: _____

RESPIRATORY

- CHOKING AT NIGHT
- SHORTNESS OF BREATH
- WHEEZING
- PRODUCTIVE COUGH
(MUCUS OR BLOOD)
- CHRONIC COUGH

CARDIOVASCULAR

- CHEST PAIN
- IRREGULAR HEARTBEAT
- SWELLING OF FEET/ANKLES
- LEG CRAMPS W/EXERCISE
- BLOOD CLOTS
- LOW BLOOD PRESSURE
- HYPERTENSION

GASTROINTESTINAL

- POOR APPETITE
- DIFFICULTY SWALLOWING
- CONSTIPATION
- DIARRHEA
- INDIGESTION
- NAUSEA
- STOMACH PAIN
- VOMITING
- BLOOD IN STOOLS

PSYCHIATRIC

- ANXIETY
- DEPRESSION
- UNUSUAL STRESS

SKIN

- ITCHING
- SKIN SORES/ULCERS
- RASHES
- DISCOLORATION

MUSCULOSKELETAL PAIN OR WEAKNESS IN:

- ARMS HIPS _____
- BACK LEGS _____
- FEET HANDS _____
- OTHER _____

GENITOURINARY (MALE & FEMALE)

- FREQUENT URINATION
- PAINFUL URINATION
- BLOOD IN URINE
- DIFFICULT URINATION
- DIFFICULT EMPYING BLADDER
- LEAKING OF URINE

ENDOCRINOLOGY

- WEIGHT GAIN
- EXCESSIVE THIRST
- MENOPAUSAL
- HAIR LOSS
- PREGNANT

OBSTETRICS & GYNECOLOGY

- NUMBER OF LIVE BIRTHS
- NUMBER OF MISCARRIAGES
- VAGINAL BIRTHS
- C-SECTIONS
- DATE OF LAST PELVIC/PAP SMEAR
- AGE AT MENARCHE
- AGE AT MENOPAUSE

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