

Western Surgical Care, PC - Patient Information

Doctor to be seen: _____ Your name: _____
Your preferred Name: _____ Maiden Name: _____ Sex: M F Marital Status: M S W D Partner
DOB: _____ Age: _____ S.S.# _____
Address: _____ City: _____ State: _____ ZIP: _____
Home phone #: _____ Cell phone #: _____ Email: _____
Employer: _____ Work phone #: _____
Referring Doctor: _____ Referring Doctor Phone #: _____
Referring Doctor Address: _____ City: _____ State: _____ ZIP: _____
Primary Care Physician (if different than above): _____ PCP Phone #: _____
Emergency Contact: _____ Relationship: _____ Contact Phone #: _____
Emergency Contact Address (if different): _____
Preferred Pharmacy: _____ Phone: _____
Pharmacy Address: _____

PLEASE CHECK ONE ANSWER IN EACH OF THE BOXES BELOW

Religion

- Buddhist Jewish
 Catholic N/A
 Hindu Other
 Islam Protestant

Race

- American Indian/Alaskan Native
 Asian
 Black/African American
 Decline
 Native Hawaiian/Pacific Islander
 Other
 White

Ethnicity

- Decline
 Hispanic or Latino
 Not Hispanic or Latino

Preferred appointment reminder method

- Email Phone
 Text

Primary Insurance Information:

Policy Holder Name: _____ Primary Ins: _____ Policy ID #: _____
Policy Holder DOB: _____ Group #: _____
Policy Holder Address: _____ Insured Relationship: _____
Policy Holder SSN: _____ Policy Holder Employer: _____

Secondary Insurance Information:

Policy Holder Name (if different): _____ Secondary Ins: _____ Policy ID #: _____
Policy Holder DOB: _____ Group #: _____
Policy Holder Address: (if different): _____ Insured Relationship: _____
Policy Holder SSN (if different): _____ Policy Holder Employee: _____

Assignment of Benefits: Please remember that insurance contracts are made between the patient and the insurance company. Often the insurance does not provide full payment of medical costs. Payment of the bill is, therefore, your responsibility. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize payment of medical benefits to Western Surgical Care, PC for services to myself.

Date: _____ Signed: X _____
"SIGNATURE ON FILE" will automatically print on your claim, allowing your insurance to pay us directly.

Records Release: I hereby authorize the release of any information, including medical and billing information, by Western Surgical Care, PC to my referring doctor and insurance company.

Date: _____ Signed: X _____

Medicare Authorization: I request that authorized Medicare benefits be made to me or on my behalf to Western Surgical Care, PC for any services furnished me by that physician/clinic/supervisor. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for the related services. I permit a copy of this authorization to be used in place of the original.

Date: _____ Signed: X _____

Medical History Questionnaire – Western Surgical Care, PC

Full Name: _____ Date of Birth: _____

Please list any other doctors you would like us to correspond with: _____

What is the reason for your visit? _____

Have you had any studies done for this? (radiology, biopsies, bloodwork) yes no

If you answered yes, please fill out the following:

Type of test?	Where was it performed?	Date of test
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical History - Please indicate all that apply to you:

- | | | |
|---|--|--|
| <input type="checkbox"/> Anal/Rectal Bleeding | <input type="checkbox"/> CPAP | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Osteopenia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Ovarian Cysts |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Oxygen Use |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Parathyroid Disease |
| <input type="checkbox"/> Blood Clot in Leg | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Blood Clot in Lung | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Posttraumatic Stress Disorder |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> GERD | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Breast Cysts | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Seizures – Grand mal |

- | | | |
|---|---|---|
| <input type="checkbox"/> Cancer- bladder | <input type="checkbox"/> Gout | <input type="checkbox"/> Seizures – Petit mal |
| <input type="checkbox"/> Cancer- breast | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Shortness of Breaty |
| <input type="checkbox"/> Cancer- cervix | <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Cancer- colon | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Spinal Cord Injury |
| <input type="checkbox"/> Cancer- esophagus | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer- Hodgkin's | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> TIA |
| <input type="checkbox"/> Cancer- kidney | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Cancer- leukemia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer- lung | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Cancer- melanoma | <input type="checkbox"/> High Cholesterol | |
| <input type="checkbox"/> Cancer- other _____ | <input type="checkbox"/> Hypertension | |
| <input type="checkbox"/> Cancer- other lymphoma | <input type="checkbox"/> Hyperthyroidism | |
| <input type="checkbox"/> Cancer- other skin | <input type="checkbox"/> Hypothyroidism | |
| <input type="checkbox"/> Cancer- ovary | <input type="checkbox"/> Ileostomy | |
| <input type="checkbox"/> Cancer- rectum/anus | <input type="checkbox"/> Incontinence | |
| <input type="checkbox"/> Cancer- stomach | <input type="checkbox"/> Irregular Heart Rate | |
| <input type="checkbox"/> Cancer- testicle | <input type="checkbox"/> Irritable Bowel Syndrome | |
| <input type="checkbox"/> Cancer- thyroid | <input type="checkbox"/> Jaundice | |
| <input type="checkbox"/> Cancer- uterus | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Kidney Stones | |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Lupus | |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Memory Impairment | |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Metal Implants (where?)_____ | |
| <input type="checkbox"/> Collapsed Lung | <input type="checkbox"/> Migraine Headache | |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Mitral Valve Prolapse | |
| <input type="checkbox"/> Colostomy | <input type="checkbox"/> Multiple Sclerosis | |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Neck Pain | |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Neuropathy | |

Please list all surgeries and the year in which they took place:

Please list all medications and supplements:

Medication

Dosage

Frequency

Medication	Dosage	Frequency
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
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Medication allergies: X-ray dye allergies, Other allergies (tape, latex, betadine, shellfish, etc.)

Family History:

Any family history of cancer? yes no

Please list member and type:

Reproductive History:

First day of last menstrual period _____

Age of menopause _____ Total number of pregnancies _____

Total number of births _____ How old were you when you gave birth the first time? _____

Did/do you breastfeed? yes no

Social History:

Married Single Divorced Separated Widowed Significant Other

Occupation: _____

Number of alcoholic beverages you drink in a week: _____

Current Smoker/tobacco user? yes no

If no: never smoked quit. When? _____

If yes: How many cigarettes / cans of tobacco/day? _____

For how many years? _____

Number of caffeinated beverages you drink in a day: _____

Coffee _____ Tea _____ Soda _____ Other _____

Review of Systems (check boxes only if symptoms currently present)

Constitutional: fever chills weight loss fatigue

Eyes: changes in vision blurred vision

HEENT: sore throat headache lightheadedness thyroid mass/problems

Breasts: lumps tenderness swelling nipple discharge/bleeding

Cardiovascular: chest pain murmurs irregular heart beat swelling in legs

Respiratory: shortness of breath wheezing cough increased sputum

Gastrointestinal: heartburn trouble swallowing nausea vomiting diarrhea

constipation bloody or maroon stools hemorrhoids

Genitourinary: frequent urination painful urination change in color of urine

Integument: rash itching new skin lesions

Neurologic: tingling/numbness seizures

Musculoskeletal: bone pain joint pain

Endocrine: loss of hair cold intolerance heat intolerance

Psychiatric: anxiety depression

Heme-Lymph: easy bleeding easy bruising

Allergic-Immunologic: sinus/allergy symptoms frequent illness

Acknowledgement of Receipt
Notice of Privacy Practices
Western Surgical Care, P.C.

I hereby acknowledge that I reviewed a copy of this medical practice's Notice of Privacy Practices.

Signed: _____ Date: _____

Telephone: _____

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient: _____

Payment Terms & Conditions

If you belong to an insurance plan we participate with, we will bill your insurance directly. The patient is liable for any deductible, co-payment, or charges that are otherwise not covered. We will bill secondary insurance for Medicare patients only. The patient is responsible for collecting all secondary insurance payments or authorizations.

If you belong to an insurance company that requires a referral (HMO or POS) to see a specialist, it is the patient's responsibility to make sure that referral is valid and current. Medical service charges denied by insurance carrier due to an invalid referral may be billed to the patient. If you have any questions about referrals or to determine if a referral is required, please contact your insurance company. If you require additional help, someone from our office will be happy to assist you.

It is the patient's responsibility to notify Western Surgical Care if you cannot keep your office appointment. A missed appointment fee may be charged to the patient's account for missed office appointments. There will be no charge for canceled office appointments when we receive notification 24 hours prior to scheduled visit.

If your account goes to a collection agency, a collection charge may be added to your account balance, and you may not be allowed to return as a patient.

I authorize benefits to be made payable to Western Surgical Care, P.C. I have read and understand the terms and conditions listed above.

PATIENT OR RESPONSIBLE PARTY: _____ DATE _____

Signature