Fayette Surgical Associates

PATIENT INFORMATION SHEET

Today's Date: _____ Social Security # _____

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. Date of Birth _____

Patient Name _____
(Last) (First) (M.I.)

Patient Address _____
(Street) (City) (State) (Zip)

Home Phone (_____) _____ Cell Phone (_____) _____

Work Phone (_____) _____ E-mail Address _____

Referring Doctor _____ Family Doctor _____
(First) (Last) (First) (Last)

Spouse/Parent/Guardian Name _____

Spouse/Parent/Guardian Social Security # _____ Birthdate _____

Emergency Contact _____ Phone (____)_____ Relationship _____

Is the patient a resident of a nursing facility? ☐ Yes ☐ No

If Yes, please list facility name: _____

_____ Phone (_____)_____
(Street) (City) (State) (Zip)

(Check One)	**RACE**	(Check One)	**ETHNICITY**	(Check One)	**Language**
	White		**Not** Hispanic/Latino		English
	Asian				Spanish
	Native Hawaiian		Hispanic/Latino		Other ( )
	Other Pacific Islander				
	Black/African American		Unreported/Refused To Report		
	American Indian/Alaska Native				
	More Than One Race				
	Unreported/Refused To Report				

INSURANCE

Primary Insurance:	**Secondary Insurance:**

WORKMANS COMP/AUTO ACCIDENT

Is your illness or condition related to: ☐ Auto Accident? ☐ Work injury? Date of Injury: _____

Workers Comp/Auto Insurance Carrier Name: _____

WC/Auto Insurance Carrier Address: _____

Employer/Auto Insurance Contact Person Name and Phone#_____

Claim Number _____

Fayette Surgical Associates

AUTHORIZATION/CONSENT

Consent To Wireless Telephone Calls: If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding appointments and billing and payment for items and services, unless I notify the practice to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from the practice, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

Consent To Email Usage: If at any time I provide an email address at which I may be contacted, unless I notify the practice to the contrary in writing, I consent to receiving appointment instructions, statements, bills, marketing material for new services and payment receipts at that email address from the practice.

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my provider, United Surgical Associates/Fayette Surgical Associates when assignment is accepted.

Patient Name: _____ Birthdate: _____

Signature: _____ Date: _____
Patient/Guardian/POA Signature

Patient Name: _____ **DOB:** _____ **Date**_____

Preferred Pharmacy: _____ **City:** _____ **Phone:** _____

REASON FOR VISIT: _____

Referring Physician: _____ **Primary Care Physician:** _____

PERSONAL HEALTH HISTORY: Please check all that apply. Anesthesia Complications: ____ Yes ____ No

	Abdominal Obesity		Coronary Artery Disease		Hiatal Hernia
	Abdominal Aortic Aneurysm		Diabetes		High Blood Pressure
	Asthma		Gallbladder Disease		High Cholesterol
	Cancer (specify):		Gallstones		Kidney Disease
	Chronic Obstructive Pulmonary Disease (COPD)		GERD		Peripheral Vascular Disease
	Congestive Heart Failure (CHF)		Hernia		Stroke

Other (specify):

SURGICAL HISTORY: (List below) or if none, please write "No surgeries"

1.	**4.**
2.	**5.**
3.	**6.**

Other (specify):

FAMILY HISTORY:

	Blood relative		Blood relative		Blood relative
Aneurysm		Diabetes		High Cholesterol	
Bleeding disorder/Blood Clots		Heart Disease		Stroke	
Cancer (specify):		High Blood Pressure		Varicose Veins	

Other (specify):

ALLERGIES/DRUG ALLERGIES: ___ No Known Drug Allergies **Drugs (specify):** _____

___ Latex ___ Shellfish **Other (specify):** _____

MEDICATIONS (with dose):

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

Additional Prescription Medications:

SOCIAL HISTORY:

Tobacco Use (circle answer): Never Smoker Former Smoker Current Smoker # ____ packs per day

Alcohol Use (circle answer): None Occasional Use Moderate Use Heavy Use

Occupation: _____ or **(circle answer)** Retired Disabled None

Patient Name: _____ DOB: _____ Date_____

REVIEW OF SYSTEMS: Please circle YES or NO to any of the following symptoms:

GENERAL			Limb Swelling	**YES**	**NO**
Chills	**YES**	**NO**	Phlebitis	**YES**	**NO**
Dietary Changes	**YES**	**NO**	Slow Pulse	**YES**	**NO**
Fatigue	**YES**	**NO**	**GASTROINTESTINAL**		
Persistent Infections	**YES**	**NO**	Abdominal Pain	**YES**	**NO**
Weight Gain	**YES**	**NO**	Black, Tarry Stool	**YES**	**NO**
Weight Loss	**YES**	**NO**	Constipation	**YES**	**NO**
SKIN			Difficulty Swallowing	**YES**	**NO**
Bruising	**YES**	**NO**	Heartburn	**YES**	**NO**
Inflammation of Skin	**YES**	**NO**	Jaundice	**YES**	**NO**
Rash	**YES**	**NO**	Nausea/Vomiting	**YES**	**NO**
Ulcer	**YES**	**NO**	Rectal Bleeding	**YES**	**NO**
HEENT			**GENITOURINARY**		
Blurred Vision	**YES**	**NO**	Blood in Urine	**YES**	**NO**
Dizziness	**YES**	**NO**	Difficulty Urinating	**YES**	**NO**
Double Vision	**YES**	**NO**	Impotence – male only	**YES**	**NO**
Headache	**YES**	**NO**	Incontinence	**YES**	**NO**
Visual Loss	**YES**	**NO**	**MUSCULOSKELETAL**		
NECK			Limb Pain with Walking	**YES**	**NO**
Neck Mass	**YES**	**NO**	**NEUROLOGICAL**		
Neck Pain	**YES**	**NO**	Fainting	**YES**	**NO**
Swollen Glands	**YES**	**NO**	Seizures	**YES**	**NO**
RESPIRATORY			Stroke	**YES**	**NO**
Chronic Cough	**YES**	**NO**	**PSYCHIATRIC**		
Shortness of Breath	**YES**	**NO**	Anxiety	**YES**	**NO**
BREAST			Depression	**YES**	**NO**
Breast Mass	**YES**	**NO**	Suicidal Ideation	**YES**	**NO**
Breast Pain	**YES**	**NO**	**ENDOCRINE**		
Breast Swelling	**YES**	**NO**	Thyroid Problems	**YES**	**NO**
Nipple Discharge	**YES**	**NO**	**HEMATOLOGY**		
Nipple Pain	**YES**	**NO**	Anemia	**YES**	**NO**
CARDIOVASCULAR			Blood Clots	**YES**	**NO**
Abnormal Blood Pressure	**YES**	**NO**	Prolonged Bleeding	**YES**	**NO**
Heart Stent	**YES**	**NO**			
Irregular Heart Rhythm	**YES**	**NO**			

Patient Name: _____ DOB: _____ Date_____

Have you had a mammogram? Yes or No When? _____ (month, day & year)

Have you had:

Colonoscopy? Yes or No When? _____ (month & year)

Fecal test? Yes or No When? _____ (month & year)

Have you had:

Pacemaker? Yes or No

Manufacturer _____ (Attach card)

Model/Serial # _____

Implant Date _____