

Fayette Surgical Associates**Saint Joseph 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 _____

If nursing home resident please list facility _____

Nursing home address _____ Phone (_____) _____

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

INSURANCE

Primary Insurance:	Secondary Insurance:
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WORKMANS COMP/AUTO ACCIDENTIs 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

Saint Joseph 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/St Joseph 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

<input type="checkbox"/>	Abdominal Obesity	<input type="checkbox"/>	Coronary Artery Disease	<input type="checkbox"/>	Hiatal Hernia
<input type="checkbox"/>	Abdominal Aortic Aneurysm	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Gallbladder Disease	<input type="checkbox"/>	High Cholesterol
<input type="checkbox"/>	Cancer (specify):	<input type="checkbox"/>	Gallstones	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	Chronic Obstructive Pulmonary Disease (COPD)	<input type="checkbox"/>	GERD	<input type="checkbox"/>	Peripheral Vascular Disease
<input type="checkbox"/>	Congestive Heart Failure (CHF)	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	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:

<u>GENERAL</u>			Limb Swelling	YES	NO
Chills	YES	NO	Phlebitis	YES	NO
Dietary Changes	YES	NO	Slow Pulse	YES	NO
Fatigue	YES	NO	<u>GASTROINTESTINAL</u>		
Persistent Infections	YES	NO	Abdominal Pain	YES	NO
Weight Gain	YES	NO	Black, Tarry Stool	YES	NO
Weight Loss	YES	NO	Constipation	YES	NO
<u>SKIN</u>			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
<u>HEENT</u>			<u>GENITOURINARY</u>		
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	<u>MUSCULOSKELETAL</u>		
<u>NECK</u>			Limb Pain with Walking	YES	NO
Neck Mass	YES	NO	<u>NEUROLOGICAL</u>		
Neck Pain	YES	NO	Fainting	YES	NO
Swollen Glands	YES	NO	Seizures	YES	NO
<u>RESPIRATORY</u>			Stroke	YES	NO
Chronic Cough	YES	NO	<u>PSYCHIATRIC</u>		
Shortness of Breath	YES	NO	Anxiety	YES	NO
<u>BREAST</u>			Depression	YES	NO
Breast Mass	YES	NO	Suicidal Ideation	YES	NO
Breast Pain	YES	NO	<u>ENDOCRINE</u>		
Breast Swelling	YES	NO	Thyroid Problems	YES	NO
Nipple Discharge	YES	NO	<u>HEMATOLOGY</u>		
Nipple Pain	YES	NO	Anemia	YES	NO
<u>CARDIOVASCULAR</u>			Blood Clots	YES	NO
Abnormal Blood Pressure	YES	NO	Prolonged Bleeding	YES	NO
Heart Stent	YES	NO			
Irregular Heart Beat	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 _____