PATIENT REGISTRATION INFORMATION:

Print Name: «FirstName» «MiddleInitial» «LastName»

Name: ______________________________ DOB: ____________________

Address: ____________________ City: ______________ State: ________ Zip: ________

Home#: ____________ Employer: ____________________ Work#: ______________

Cell#: ____________ Social Security #: ________________ Gender: ☐ Male ☐ Female

Marital status: ☐ Married ☐ Single ☐ Widow/er ☐ Divorced

Primary Physician: ____________________ Referring Doctor: ____________________

SPOUSE OR PARENT INFORMATION:

Name: ______________________________ DOB: ____________________

Address: ____________________ City: ______________ State: ________ Zip: ________

Home#: ____________ Work#: ____________ Cell#: ____________________

Employer: ____________________ Employer Phone#: ____________ SS#: ____________

INSURANCE INFORMATION:

Name of Insurance: ____________________ Name of Policy Holder: ____________________

Insurance ID#: ________________ Group #: ____________ Employer: ______________

Policyholder DOB: ________ SS#: ____________ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

SECONDARY INSURANCE INFORMATION:

Name of Insurance: ____________________ Name of Policy Holder: ____________________

Insurance ID#: ________________ Group #: ____________ Employer: ______________

Policyholder DOB: ________ SS#: ____________ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

EMERGENCY CONTACT: (NOT LIVING WITH YOU) ________________________________

Relationship to you: ______________ Home#: ______________ Cell#: ______________

ADDITIONAL INFORMATION

CALLS & MESSAGES:

You can leave messages at home ☐ Yes ☐ No
You can leave messages at work ☐ Yes ☐ No
You can leave message on cell ☐ Yes ☐ No
You may email me at above email ☐ Yes ☐ No
You may access my RX external history ☐ Yes ☐ No

Appointment Reminder ☐ Home ☐ Cell ☐ Work

Email: ______________________________

Requested PHARMACY: ____________________ Requested Laboratory: ____________________

Ethnicity: ☐ Caucasian ☐ Hispanic ☐ American Indian ☐ African American ☐ Pacific Islander ☐ Other

I hereby consent for treatment and give authorization for payment of insurance benefits to be made directly to Carson Surgical Group and any assisting physicians for services rendered. The above information I have provided is current an accurate. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. I hereby authorize this healthcare provider to release any information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be valid as original

Signature: ________________________ Date ________________________

Timothy J. King, M.D. FACS, Kevin D. Halow, M.D. RVT, FCCP, FACS,
Shannon H. Beal, M.D. RPVI Douglas S. Wiseman, M.D.
Tania J. Dickson-Humphries, PA-C Ashley H. Vazeen, APRN

WELCOME TO OUR OFFICE

Thank you for choosing Carson Surgical Group for your medical care. We are committed to providing care, which is efficient, courteous and competent.

Please understand that payment, accurate billing and collections of your bill are considered a part of your treatment. Necessary forms need to be completed to expedite carrier payment. It is your responsibility to provide us with your most current insurance information.

Please bring: Insurance card(s), Picture ID, Medication list, Surgical history

OUR FINANCIAL POLICY: (Please take time to read)

1) If you have a balance with us after your insurance has paid you are required to pay the balance in full within 30 days of your first statement.

2) If you have not paid within 90 days and have NOT made payment arrangements your account will be referred out.

3) When your account is referred to an outside collection agency your balance will be increased by 50% for collection processing. This can and will impact your financial credibility. This is a substantial amount added to your current balance.

4) If you are scheduled for ultrasound(s) or Office surgery and do not provide at least 24 hour notice of cancellation you will be charged $200.00 as a no show fee.

5) If you reschedule more than two (2) times for ultrasounds or an office surgery with less than 24 hour notice you will not be rescheduled.

If you know that you will need assistance paying your balance in full contact us immediately. We will work with you but you must contact us to make these arrangements.

Disclosure:

I understand that if my insurance carrier denies any charges or I have no insurance to file for services I am responsible for the bill. I have read the financial policy and understand my responsibility. I am responsible for any deductibles, co-payments or co-insurance at the time of service.

Signature:______________________________ Date:__________________________

«FirstName» «MiddleInitial» «LastName»

HEALTH HISTORY QUESTIONNAIRE

Print Name: «FirstName» «MiddleInitial» «LastName»

Why are we seeing you today? _______________

HEIGHT : __________WEIGHT: ___________

Please mark if you have HAD any of the following:

☐ Asthma
☐ Arrhythmia ☐ Atrial Fibrillation
☐ Angina ☐ Acid Reflux
☐ Bleeding disorders
☐ Blood thinners ☐ Kidney Disease
☐ Cancer ☐ Chronic pain
☐ Congestive heart failure ☐ COPD ☐ Chest pain
☐ Diabetes: ☐ Insulin ☐ Oral Med ☐ Diet
☐ Depression
☐ Difficult Airway ☐ Difficult intubations
☐ Emphysema ☐ Food allergies ☐GERD
☐ Hepatitis A☐ B☐ C☐
☐ History of nausea/vomiting after surgery
☐ History of CLOTS: ☐Legs ☐Lungs ☐Arms
☐ HIV / AIDS
☐ Hiatal hernia
☐ High blood pressure
☐ Unusual reaction to anesthesia (Self or family member?)

☐ Heart Attack: Date:
☐ Heart Surgery:
☐ Date: _________ Dr.
☐Yellow / Jaundice
☐ Latex allergy
☐ Migraines ☐Malignant Hyperthermia
☐ Oxygen at home: ☐ All the time
☐ Just at night How many liters?
☐ Pseudocholinesterase deficiency (sensitive to Anectine)
☐ Panic disorder
☐ Pacemaker ☐ AICD
☐ Renal failure ☐ Rheumatoid arthritis
☐ Seizures Date of last one: ______________________
☐Sleep Apnea, Diagnosed
☐ CPAP use ☐BIPAP use
☐ Stroke ☐TIA
☐ TB ☐Thyroid problems

Describe: ____

Are you a smoker? ☐ Yes ☐ No Packs per day ______ ☐ Cigar/Pipe How often? _______________________

Have you ever smoked ☐Yes ☐ No When did you quit? ____________________________

Alcohol Use: ☐ Yes ☐ No How often? _____________ Drug Use: ☐Yes ☐No

Do you take ASPIRIN? 81mg or higher ☐Yes ☐ No

Have you ever had a PNEUMOCOCCAL immunization? ☐ Yes ☐ No

Have you had a INFLUENZA vaccine this flu season ☐ Yes ☐ No

Have you had a Mammogram in the last 2 years Yes ☐ No ☐
Have you had a Colonoscopy in the last 10 years Yes ☐ No ☐

CURRENT MEDICATION (Include prescriptions, supplements & OTC)

Drug Name	Dose	Reason	Drug Name	Dose	Reason

DRUG ALLERGIES

LIST ALL PREVIOUS SURGERIES

FAMILY HISTORY:	Mother	Father		Mother	Father		Mother	Father
Breast Cancer	☐	☐	Genetic Disease	☐	☐	Prostate Cancer	☐	☐
Blood clotting problems	☐	☐	Colon Cancer	☐	☐	Bleeding Problems	☐	☐

REVIEW OF SYSTEMS: Mark squares if You, the patient, have ever experienced any of the following:

SYSTEMIC PROBLEMS
- ☐ Fever/Chills
- ☐ Loss
- ☐ Fatigue
- ☐ Night Sweats

EYES
- ☐ Episodes of blindness
- ☐ Wear glasses
- ☐ Double Vision

EARS, NOSE AND THROAT
- ☐ Hearing difficulties
- ☐ Dental Problems
- ☐ Nose Bleeds
- ☐ Sore Throat
- ☐ Hoarse Throat

CARDIOVASCULAR
- ☐ Palpitations
- ☐ Chest Pain/Pressure
- ☐ Dizzy Spells
- ☐ Short of Breath at night
- ☐ Need extra pillow to breathe
- ☐ Swollen Ankles
- ☐ Heart Murmur

RESPIRATORY
- ☐ Cough up phlegm/blood
- ☐ Shortness of breath
- ☐ Chest colds/bronchitis
- ☐ Asthma

DIGESTIVE
- ☐ Problems swallowing
- ☐ Stomach pains
- ☐ Black stools
- ☐ Constipation
- ☐ Heartburn
- ☐ Diarrhea
- ☐ Pain in rectum
- ☐ Rectal bleeding

GENITOURINARY
- ☐ Day - or - ☐ Night frequency
- ☐ Burning in urination
- ☐ Abnormal color in urine
- ☐ Urgency

Men
- ☐ Weak stream Weight
- ☐ Prostate trouble
- ☐ Burning or discharge
- ☐ Lumps on testicles

Women
- ☐ Last menstrual period
- ☐ Post menopausal
- ☐ Abnormal vaginal bleeding
- ☐ Last PAP smear ______________________
- ☐ Abnormal PAP smear
- ☐ Pregnant now?

How many pregnancies __________________

How many normal births _________________

MUSCULOSKELETAL
- ☐ Aching muscles ☐ Aching joints
- ☐ Leg or calf pain ☐ Cramping

BREAST
- ☐ Lumps ☐ Pain ☐ Nipple discharge

SKIN ☐ Cancer ☐ Disorder: _______________

NEUROLOGICAL
- ☐ Weakness ☐ Numbness
- ☐ Convulsions

PSYCHIATRIC
- ☐ Hopeless outlook
- ☐ Work/family problems
- ☐ Contemplated suicide
- ☐ Sexual difficulties

ENDOCRINE
- ☐ Abnormal thyroid
- ☐ Abnormal development

HEMATOLOGICAL / LYMPHATIC
- ☐ Lumps: ☐ Neck ☐ Armpit ☐ Groin
- ☐ Bleed easily
- ☐ Abnormal bruising

ALLERGIC / IMMUNOLOGICAL
- ☐ Unusual allergies
- ☐ Frequent infectious disease

Please list any additional information about your health or physical/mental condition that would help staff with your care:

____

____

____

Print Name: «FirstName» «MiddleInitial» «LastName»

Signature: ____ Date: ___________________________

HIPAA

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can be and will be used to:

*Conduct, plan and direct my treatment and follow up care among the multiple healthcare providers whom may be involved in the treatment directly or indirectly.

*Obtain payment from third-party payers.

*Conduct normal healthcare operations such as quality assessments and physician certifications.

A COMPLETE DISCLOSURE OF THE NOTICE OF PRIVACY PRACTICES WAS OFFERED TO ME

1. Please list the family members or other person, if any, whom we may inform about your general medical condition, diagnosis, appointments, test results, or other health care information (including treatment, payment and healthcare operations). You are not required to list anyone, but if you do you are authorizing that person to have complete access to your medical and/or payment information.

Name: ______________________________Relationship: ________________ Phone: _____________________

Name: ______________________________Relationship: ________________ Phone: _____________________

Name: ______________________________Relationship: ________________ Phone: _____________________

2. Our office staff will NOT leave any confidential health information on voicemail. We will only leave a call back number for your prompt attention to reach us during business hours.

3. If you have any special requests please inform our receptionist or your Health Care staff.

I have read and understand this form and agree with all statement made

Patient Signature: ______________________________ Date: _________________________

Relationship to patient: ___________________________

Name: «FirstName» «MiddleInitial» «LastName»

PATIENT NAME: «FirstName» «MiddleInitial» «LastName» ______ «DOB» DATE: ______________________

Did you have a drink containing alcohol in the past year?

☐ Yes

☐ No

If 'Yes' : How often did you have a drink containing alcohol in the past year?

☐ Never (0 points)

☐ Monthly or less (1 point)

☐ Two to four times a month (2 points)

☐ Two to three times per week (3 points)

☐ Four or more times a week (4 points)

If 'Yes' : How many drinks did you have on a typical day when you were drinking in the past year?

☐ 1 or 2 (0 points)

☐ 3 or 4 (1 point)

☐ 5 or 6 (2 points)

☐ 7 to 9 (3 points)

☐ 10 or more (4 points)

If 'Yes' : How often did you have six or more drinks on one occasion in the past year?

☐ Never (0 points)

☐ Less than monthly (1 point)

☐ Monthly (2 points)

☐ Weekly (3 points)

☐ Daily or almost daily (4 points)

Points ☐

Interpretation

☐ Positive

☐ Negative

Interpretation

The AUDIT-C is scored on a scale of 0-12 (scores of 0 reflect no alcohol use).

- In men, a score of 4 or more is considered positive.
- In women, a score of 3 or more is considered positive.