

Cahaba Valley Surgical Group, PC

Patient Information Form

Demographic Information:		Today's Date:	
Last Name:	First:	Middle:	
Called By:	Maiden:		
Date of Birth:	Gender:	F M U	Soc. Sec. #
Marital Status:	M S W D Part.	DL #:	
Address:			
Zip:	City:	ST:	
Phone #	Home:	Work:	Cell:
Fax:	Email:		
Employer:	Occupation:	Phone:	
Spouse:	Occupation:		
Financially Responsible Party:	<input type="checkbox"/> Self or list here:		
Relationship:	Contact Info:		
Billing Address:	Is your billing address different than the address above?		
Insurance Information:	Do you have health insurance you want us to file?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this visit due to injury or accident?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Is this a worker's compensation claim?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Insurance Co. #1	Contract / ID #	Group #	
Effective Date:	Are you the <u>Insured/Subscriber</u> or <u>Spouse</u> or <u>Dependent</u> on this policy?		
List the name or subscriber of this policy EXACTLY as listed on the insurance card:			
Subscriber DOB:	SSN:	-	-
Insurance Co. #2	Contract / ID #	Group #	
Effective Date:	Are you the <u>Insured/Subscriber</u> or <u>Spouse</u> or <u>Dependent</u> on this policy?		
List the name or subscriber of this policy EXACTLY as listed on the insurance card:			
Subscriber DOB:	SSN:	-	-
Referrals:	Who is your referring physician?	City/ST	
Who is your primary physician (if different)?		City/ST	
Privacy Notice:	Please note that we maintain a Notice of Privacy Practices , which is posted at several locations in our waiting room. We also have copies that are accessible at the front desk that we encourage you to take and familiarize yourself.		
List any individuals with whom you give us permission to discuss your account and medical information, including but not limited to treatment, diagnosis, medications, test results or other types of protected health information in order to facilitate or coordinate treatment and payment for your services. You understand that the release of your information is voluntary and does not affect your access to treatment. You can choose NOT to disclose your information if you wish. You can revoke this authorization at any time by writing to Cahaba Valley Surgical Group, PC, or by filling out a new form.			
Name	Relationship	Contact #	
Name	Relationship	Contact #	
Name	Relationship	Contact #	

The staff of Cahaba Valley Surgical Group, P.C. thank you for entrusting us with your healthcare. **Please read this statement carefully and sign at the bottom of this form.**

I acknowledge that I am presenting to this office for evaluation and treatment, which may include surgery. I authorize the release of any medical, insurance or other information necessary to treat me and coordinate my care, to process claims on my behalf, and authorize Cahaba Valley Surgical Group to do so if I have indicated that I have insurance for my services. I agree to be fully responsible for all lawful debts incurred for services I receive from Cahaba Valley Surgical Group, P.C., as well as medical services provided in any hospital setting necessary, whether covered by my insurance or not, including any collections fees if I do not pay my bill. I understand that my insurance may have a deductible, coinsurance, non-covered services, and/or pre-existing condition provisions and I will be fully responsible for any patient responsibilities as indicated by my insurance company.

Patient Signature (or Responsible Party/Guardian) _____ **Date** _____

Cahaba Valley Surgical Group, PC

Medical Evaluation Form

Today's Date: ____/____/____

Patient Name _____ Date of Birth ____/____/____ Age ____

Patient Height: _____ Weight _____ lbs. BMI _____ (Body Mass Index, if known)

Primary Care Physician: _____ Specialist (eg. Cardiologist) _____
(Or Referring Physician)

Reason for visit (chief complaint): _____

Medical History: None (Check or circle all that apply)

<input type="checkbox"/> Alzheimer's <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Bleeding disorder <input type="checkbox"/> Blood Clots <input type="checkbox"/> Blood transfusions <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts	<input type="checkbox"/> Colitis <input type="checkbox"/> Cholesterol <input type="checkbox"/> Diabetes – Type I <input type="checkbox"/> Diabetes- Type II <input type="checkbox"/> Emphysema <input type="checkbox"/> Enlarged prostate <input type="checkbox"/> Gastric reflux <input type="checkbox"/> Glaucoma	<input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Heart Failure <input type="checkbox"/> Hiatal hernia <input type="checkbox"/> Hypertension <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Heart valve <input type="checkbox"/> Intestinal problems <input type="checkbox"/> Kidney stones	<input type="checkbox"/> Lung disease <input type="checkbox"/> Malignant hyperthermia <input type="checkbox"/> Mental illness <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Mitral valve prolapsed <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Post-Menopausal <input type="checkbox"/> Poor Circulation (PVD)	<input type="checkbox"/> Renal Failure <input type="checkbox"/> Seizures <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Stomach ulcers <input type="checkbox"/> Stroke <input type="checkbox"/> TB <input type="checkbox"/> Thyroid problems <input type="checkbox"/> LMP: ____/____
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Other _____

Surgical History: None (Check or circle all that apply and indicate the year)

<input type="checkbox"/> Appendectomy__ <input type="checkbox"/> Amputation __ <input type="checkbox"/> Back__ <input type="checkbox"/> Bladder__ <input type="checkbox"/> Breast biopsy__ <input type="checkbox"/> Breast augmentation <input type="checkbox"/> Cystoscopy__	<input type="checkbox"/> Carotid Endarterectomy__ <input type="checkbox"/> Carpal tunnel__ <input type="checkbox"/> Cataract__ <input type="checkbox"/> Colon__ <input type="checkbox"/> Diagnostic laparoscopy__ <input type="checkbox"/> D & C__	<input type="checkbox"/> Gallbladder __ <input type="checkbox"/> Gastric banding/stapling__ <input type="checkbox"/> Gastric bypass__ <input type="checkbox"/> Heart__ <input type="checkbox"/> Hernia__ <input type="checkbox"/> Hemorrhoidectomy__	<input type="checkbox"/> Hysterectomy__ <input type="checkbox"/> Joint replacement__ <input type="checkbox"/> Knee Arthroscopy__ <input type="checkbox"/> Knee Replacement__ <input type="checkbox"/> Lung__ <input type="checkbox"/> Mastectomy__	<input type="checkbox"/> Prostate__ <input type="checkbox"/> Reflux (Nissen) __ <input type="checkbox"/> Stent Artery (heart/leg) <input type="checkbox"/> Shoulder Surgery__ <input type="checkbox"/> Thyroid__ <input type="checkbox"/> Tonsils__ <input type="checkbox"/> Tubal Ligation__
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Other _____

Medications: *please list all current medications, dose strength, and frequency taken – please include supplements, vitamins, & herbs*

Drug Allergies: (please list drug and reaction) _____

Other Allergies: _____

Family History: *please list illness in your family and/or cause of death (if applicable)* Adopted or unknown

Please indicate below significant medical problems of family members. Indicate which family members by <u>checking</u> (X) the appropriate column.	Mother	Father	Brother	Sister
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (Type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History: (check or circle which best describes you)

Married Single Divorced Widowed Other
 Employed (job description: _____) Unemployed Retired _____
 Student (grade/level _____) Disability (due to _____ ; year _____)

Do you now or have you ever?

Used alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	(<input type="checkbox"/> Rarely <input type="checkbox"/> Regularly <input type="checkbox"/> Frequently)	How long:	Stopped
Used illicit drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	(<input type="checkbox"/> Rarely <input type="checkbox"/> Regularly <input type="checkbox"/> Frequently)	How long:	Stopped
Used tobacco? ____/day	<input type="checkbox"/> Yes <input type="checkbox"/> No	(<input type="checkbox"/> Rarely <input type="checkbox"/> Regularly <input type="checkbox"/> Frequently)	How long:	Stopped
Smokeless tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	(<input type="checkbox"/> Rarely <input type="checkbox"/> Regularly <input type="checkbox"/> Frequently)	How long:	Stopped

Cahaba Valley Surgical Group, PC

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

I hereby give permission to **Cahaba Valley Surgical Group, P.C.**, located at 1004 First Street North, Shelby Medical Plaza Suite 250, Alabaster, Alabama 35007 (Dr. Rex A Sherer, Dr. Richard D. Stahl, Dr. Tim L Christopher, and Dr. Vince W. Gardner) to release and/or obtain medical records to physician practices, hospitals, places of emergent care, or insurance companies that are involved in my care.

Medical records may include (but may not be limited to) the following documents. Please indicate if you only want specific documents disclosed by indicating to the right of the selection. If you do not indicate specific or limited records, you entire record will be disclosed as directed:

- ❖ Labs and diagnostic tests _____
- ❖ Pathology _____
- ❖ Radiology _____
- ❖ History and Physical Data _____
- ❖ Database Information _____
- ❖ Financial Information _____
- ❖ Complete Records of the Patient File _____

This authorization shall be in effect for as long as I am a patient of Cahaba Valley Surgical Group, P.C.

Or

This authorization shall expire on ____/____/200____.

Signature of Patient or Authorized Parent or Guardian

Date Signed: _____