

Cahaba Valley Surgical Group, PC

Patient Information Form

| | | | | | |
|--|--|---|--|--|----------------|
| Demographic Information: | | | | Chart# | |
| Last Name: | | First: | | Middle: | |
| Called By: | | Maiden: | | | |
| Date of Birth: | | Gender: F M U | | Soc. Sec. # | |
| Marital Status: M S W D Other | | Preferred Language: | | Race/Ethnicity: | |
| Address: | | | | | |
| Zip: | | City: | | ST: | |
| Phone #s | | Home: | | Work: | |
| Cell: | | | | | |
| Email: | | Preferred contact: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> Web portal | | | |
| Preferred Pharmacy City/St/Phone: | | | | | |
| 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 <input type="checkbox"/> Insured/Subscriber <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent 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 <input type="checkbox"/> Insured/Subscriber <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent 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, medications and diagnostic tests. 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 assign benefits for payment of insurance claims directly to the practice. 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 Guardian) _____ **Date** _____

Cahaba Valley Surgical Group, PC

Medical Evaluation Form

Patient Name _____ Date of Birth ____/____/____ Age ____
 Patient Height: _____ Weight _____ lbs. BMI _____ (Body Mass Index, if known) Today's Date: ____/____/____
 Primary Care Physician: _____ Specialist (eg. Cardiologist) _____
 (Or Referring Physician)

Reason for visit (chief complaint): _____

Medical History: (Or None of these) (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: ____/____ |
|---|--|---|--|--|

Other _____

Surgical History: (Or None of these) (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__ |
|---|---|---|---|---|

Other _____

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

| Name of Medication | dosage | freq | Name of Medication | dosage | freq | Name of Medication | dosage | freq |
|--------------------|--------|------|--------------------|--------|------|--------------------|--------|------|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

★**Drug Allergies:** (please list drug and reaction) _____

★**Other Allergies** (foods, pets, environmental): _____

Family History: please list illness in your family

| | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 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 _____)

| Substance Use (check) | Current | Past | Never | Comments (frequency, amount, age started/stopped) |
|-----------------------|--------------------------|--------------------------|--------------------------|---|
| Alcohol Use | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Tobacco Use | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Illicit Drug Use | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Smokeless tobacco | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

Are you currently experiencing...?

Medical Evaluation Form

Chart # _____

Name: _____

(Please check all that apply)

| | |
|--|--|
| <p><u>Constitutional / General</u> <input type="checkbox"/> (Or None of these)</p> <p><input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss</p> <p><input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Fatigue <input type="checkbox"/> Body aches</p> | <p><u>Genitourinary (Urologic, GYN)</u> <input type="checkbox"/> (Or None of these)</p> <p><input type="checkbox"/> Blood in urine <input type="checkbox"/> Burning on urination <input type="checkbox"/> Pelvic pain</p> <p><input type="checkbox"/> Difficulty voiding <input type="checkbox"/> Incontinence/wetting</p> <p><input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Abnormal uterine bleeding</p> |
| <p><u>Eyes</u> <input type="checkbox"/> (Or None of these)</p> <p><input type="checkbox"/> Impaired vision <input type="checkbox"/> Blurred vision</p> <p><input type="checkbox"/> Recent changes in vision</p> | <p><u>Neurological</u> <input type="checkbox"/> (Or None of these)</p> <p><input type="checkbox"/> Headache <input type="checkbox"/> Light headed/dizzy <input type="checkbox"/> Seizure</p> <p><input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Memory difficulties</p> |
| <p><u>HENT (Ear, Nose Throat)</u> <input type="checkbox"/> (Or None of these)</p> <p><input type="checkbox"/> Hearing loss <input type="checkbox"/> Sore throat <input type="checkbox"/> Sinus drainage</p> <p><input type="checkbox"/> Neck tenderness <input type="checkbox"/> Dental problems <input type="checkbox"/> Thyroid mass</p> | <p><u>Musculoskeletal</u> <input type="checkbox"/> (Or None of these)</p> <p><input type="checkbox"/> Joint pain <input type="checkbox"/> Foot/leg ulcers <input type="checkbox"/> Muscle weakness</p> <p><input type="checkbox"/> Muscle cramps <input type="checkbox"/> Back pain <input type="checkbox"/> Muscle Pain</p> |
| <p><u>Breast</u> <input type="checkbox"/> (Or None of these)</p> <p><input type="checkbox"/> Breast pain <input type="checkbox"/> Breast lump <input type="checkbox"/> Nipple drainage</p> <p><input type="checkbox"/> Breast Tenderness</p> | <p><u>Endocrine</u> <input type="checkbox"/> (Or None of these)</p> <p><input type="checkbox"/> Cold intolerance <input type="checkbox"/> Heat intolerance</p> <p><input type="checkbox"/> Hair loss <input type="checkbox"/> Hot Flashes</p> |
| <p><u>Cardiovascular (Heart)</u> <input type="checkbox"/> (Or None of these)</p> <p><input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Swelling in legs/feet</p> <p><input type="checkbox"/> Varicose veins <input type="checkbox"/> Leg pain with walking</p> | <p><u>Psychiatric</u> <input type="checkbox"/> (Or None of these)</p> <p><input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Abnormal stress</p> <p><input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Impulsive Behaviors</p> |
| <p><u>Respiratory</u> <input type="checkbox"/> (Or None of these)</p> <p><input type="checkbox"/> Cough <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Asthma/wheezing <input type="checkbox"/> Sleep Apnea</p> | <p><u>Hematologic / Lymphatic</u> <input type="checkbox"/> (Or None of these)</p> <p><input type="checkbox"/> Easy bruising <input type="checkbox"/> Easy bleeding</p> <p><input type="checkbox"/> Lymph node enlargement</p> |
| <p><u>Gastrointestinal</u> <input type="checkbox"/> (Or None of these)</p> <p><input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Reflux</p> <p><input type="checkbox"/> Heartburn <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Blood in stool <input type="checkbox"/> Mouth ulcers <input type="checkbox"/> Hemorrhoids</p> | <p><u>Allergic / Immunologic</u> <input type="checkbox"/> (Or None of these)</p> <p><input type="checkbox"/> Sinus allergy symptoms <input type="checkbox"/> Allergic dermatitis</p> <p><input type="checkbox"/> Frequent allergic illnesses</p> |

Regarding the main reason you are here today, When did these symptoms begin? _____
Mild Mod. Severe

How long do they last? _____ How severe? (check) 1 2 3 4 5

What treatment options have you tried? _____

Have you had any diagnostic tests for these problems (labs, X-rays, etc.)? _____

Reproductive History (Female Patients):

Menstrual History: When was your last menstrual period? _____
 Your age at first menstrual period? _____ Age of menopause (if applicable)? _____

Obstetrical History: # of Pregnancies _____ # of Miscarriages _____ # of Live Births _____

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your private health and financial information is protected by federal and state laws. We are required to uphold specific standards to protect and secure that information. By presenting to our office and signing below, you hereby consent for Cahaba Valley Surgical Group, PC to use or disclose information about yourself (or another person for whom you have the authority to sign) for the sole purposes of treatment (coordinating, arranging and delivering care, including referrals to other healthcare providers for your treatment), payment (which may include filing claims or sending statements, including medical information to support processing claims) and health care operations. You may refuse to sign this consent form.

We maintain a Notice of Privacy Practices which is posted in our office, of which copies are available to you at our registration desk.

You have the right to request that the Practice restrict how protected health information (PHI) is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to requested restrictions; however; if the Practice agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

AUTHORIZATION FOR COMMUNICATIONS

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Cahaba Valley Surgical Group, PC representative or my physician direct to me by mail, telephone, e-mail, or publish to a secure encrypted website (if I so indicate) communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Cahaba Valley Surgical Group, PC to that effect in writing.

TREATMENT CONSENT

I hereby consent to evaluation, testing, and treatment as directed by my Cahaba Valley Surgical Group, PC. physician or his/her designee.

Acknowledged-

Signature

Date