

Cahaba Valley Surgical Group, PC

Patient Information Form

Demographic Information:				Chart#	
Last Name:		First:		Middle:	
Called By:		Maiden:			
Date of Birth:		Gender:		Soc. Sec. #	
		F M U			
Marital Status:		DL #:			
		M S W D Part.			
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

Chart # _____

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

Other _____

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

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

Family History: please list illness in your family

Please indicate below significant medical problems of family members. Indicate which family members by checking (X) the appropriate column.

	Mother	Father	Brother	Sister
Heart Disease				
High Blood Pressure				
Diabetes				
Cancer (Type)				
Other:				

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

Are you currently experiencing....?

Medical Evaluation Form

Chart # _____

Name: _____

(Please circle all that apply)

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

Cahaba Valley Surgical Group, PC

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Chart # _____

Date of Birth: _____ Social Security Number: _____

I hereby give permission to **Cahaba Valley Surgical Group, P.C.**, located at 644 2nd Street North, Shelby Medical Building Suite 206, Alabaster, Alabama 35007 (Dr. Rex A Sherer, 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:

- ❖ 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: _____