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PATIENT INFORMATION

Last name, First name ____ Date of Birth___________________________

SS #_____________________________ Sex: Male / Female Marital Status: S M D W

Street Address____ City____________________ State______ Zip__________

Home Phone #______________________________ Cell Phone #_______________________________

Work Phone #______________________________ Ext:______________ Employer________________________________

Dr. you are seeing today ___________________________________

Referring Dr. & Phone________________________________ Family Dr. &Phone___________________________________

EMERGENCY CONTACT/NEXT OF KIN_______________________________ PHONE#___________________________

INSURANCE INFORMATION

1. PRIMARY INS. CO.___________________________________ Insured's Name_______________________________

Date of Birth: _______________ I.D. #______________________ Gp #_____________________ SS #________________

Effective Date of Coverage ___________________ Relationship to Patient _________________ Employer ______________

2. SECONDARY INS. CO.________________________________ Insured's Name_________________________________

Date of Birth:_______________ I.D. #_____________________ Gp #______________________ SS #_________________

Effective date of Coverage ___________________ Relationship to Patient _________________ Employer________________

AUTHORIZATION

___________________________________ __________ ____

(Patient's Signature) (Date) (Power of Attorney or Authorized Signature if Minor)

I understand that I am responsible for my payment of services to Columbia Surgical Associates, Inc. I authorize the Release of any and all medical records information necessary to process claim/s and request payment from my Insurance Company as complies with HIPAA regulations.

WORKER'S COMPENSATION/LIABILITY INFORMATION

Is this visit related to a work injury? ____Yes ____ No Is this visit related to an auto accident? ____ Yes ____No

Is this visit related to any other liability claim? ____Yes ____No

I have written authorization from the Insurance Company for these services: ____ Yes ____No

This claim has been filed with the Missouri State Dept. of Worker's Compensation: ____Yes ____No

If "yes" please give the report of injury number (#) ____________________________________.

I AUTHORIZE COLUMBIA SURGICAL ASSOCIATES, INC. AND/OR IT'S REPRESENTATIVE TO RELEASE MY MEDICAL RECORDS OR DISCUSS CONTINUED TREATMENT OF CARE WITH MY WORKMAN'S COMPENSATION CARRIER OR ITS REPRESENTATIVE.

____ _____________________

Patient Signature Date

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Do you now or have you recently had any problems related to the following systems? Circle YES or NO. If you mark yes to any of the following, please indicate which doctor is treating you for that problem. If you haven't seen a physician yet, please contact your Internist or Family Physician to address those issues.

Name: ________________________ **Date of Birth:**__________________

Cardiovascular:
Chest pain **Y**☐ **N**☐
Palpatations/Murmur **Y**☐ **N**☐
Leg swelling **Y**☐ **N**☐
Irregular Heartbeat **Y**☐ **N**☐
Other: ___________________________________

Constitutional Symptoms:
Fever **Y**☐ **N**☐
Chills **Y**☐ **N**☐
Headache **Y**☐ **N**☐
Weight Loss **Y**☐ **N**☐
Weight Gain **Y**☐ **N**☐
Other: ______________________________________

Endocrine:
Excessive Thirst **Y**☐ **N**☐
Too hot/cold **Y**☐ **N**☐
Tired/Sluggish **Y**☐ **N**☐
Other: ______________________________________

Eyes:
Blurred Vision **Y**☐ **N**☐
Double Vision **Y**☐ **N**☐
Pain **Y**☐ **N**☐
Other: ______________________________________

Integumentary/ Breast:
Skin rash **Y**☐ **N**☐

Breast
Nipple Discharge **Y**☐ **N**☐
Breast Pain **Y**☐ **N**☐
Mammogram **Y**☐ **N** ☐
Date________ ☐Normal ☐Abnormal

Genitourinary:
Urine retention **Y**☐ **N**☐
Painful urination **Y**☐ **N**☐
Urinary frequency **Y**☐ **N**☐
Difficulty Urinating **Y**☐ **N**☐
PSA (prostate blood test) **Y**☐ **N**☐
Date________ ☐ Normal ☐Abnormal
Other: _____________________________________

Hematological/Lymphatic:
Swollen glands **Y**☐ **N**☐
Blood clotting problem **Y**☐ **N**☐
Other: ______________________________________

Musculoskeletal:
Joint Pain **Y**☐ **N**☐
Neck Pain **Y**☐ **N**☐
Back Pain **Y**☐ **N**☐
Assistive devices **Y**☐ **N**☐
Other: _____________________________________

Neurological:
Seizures **Y**☐ **N**☐
Tremors **Y**☐ **N**☐
Dizzy Spells **Y**☐ **N**☐
Numbness/Tingling **Y**☐ **N**☐
Other: _______________________________________

Psychological:
Do you suffer from depression? **Y**☐ **N**☐
Do you feel severely anxious or nervous? **Y**☐**N**☐
Other: _______________________________________

Respiratory:
Wheezing **Y**☐ **N**☐
Frequent cough **Y**☐ **N**☐
Chronic Cough **Y**☐ **N**☐
Shortness of breath **Y**☐ **N**☐
Other: ____________________________________

Gastrointestinal:
Abdominal pain **Y**☐ **N**☐
Nausea/Vomiting **Y**☐ **N**☐
Indigestion/Heartburn **Y**☐ **N**☐
Ulcer **Y**☐ **N**☐
Intolerance to Greasy Food **Y**☐ **N**☐
Blood in Stool **Y**☐ **N**☐
Colon/Rectal Polyps **Y**☐ **N**☐
Pain with Bowel Movement **Y**☐ **N**☐
Jaundice **Y**☐ **N**☐
Difficulty swallowing **Y**☐ **N**☐
Have you had a colonoscopy ?
Y☐ **N**☐
When?______________
Results ☐**Normal** ☐ **Abnormal**
Other________________________________

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Patient Name: ______________________________

HISTORY OF PRESENTING ILLNESS:

REASON FOR OFFICE VISIT: ____________________________________

What makes this better or worse? ______________________________________

Date illness started:____________________ Severity of pain 1-10 (10 being worst)____

Quality of pain (stabbing, pressure-like):_____________________________________

Height ________ Weight ________ Age:Age Date of Birth: Date of Birth

HEALTH HISTORY:

Please list all surgeries:

	SURGERY	DATE	COMPLICATIONS
☐	Hernia		
☐	Gall Bladder		
☐	Appendectomy		
☐	Hysterectomy		
☐	Orthopedic Surgery		
☐	Other		
☐	Other		
☐	Other		
☐	Other		

Please list all Hospitalizations:

HOSPITALIZATIONS	DATE	REASON

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Patient Name:______________________________

Please Circle "Y" or "N" for any medical conditions YOU suffer from:

Anemia	Y	N	Frequent Headache/Migraine	Y	N	Liver Disease/Jaundice	Y	N
Arthritis	Y	N	Gall Bladder	Y	N	Meningitis	Y	N
Asthma	Y	N	Head Injury	Y	N	Multiple Sclerosis	Y	N
Bladder/Prostate Problems	Y	N	Hearing Problems	Y	N	Pneumonia	Y	N
Blood Clots	Y	N	Heart Attack	Y	N	PVD (peripheral vascular disease)	Y	N
Blood Transfusion	Y	N	Heart Catheterizations	Y	N	Rheumatic Fever	Y	N
Cancer - Breast	Y	N	Heart Problems	Y	N	Stroke	Y	N
Cancer - Colon	Y	N	Hepatitis	Y	N	Thyroid Disorder	Y	N
Cancer- Other: __________	Y	N	Hiatal Hernia/Reflux	Y	N	Tuberculosis	Y	N
Colon/Rectal Polyps	Y	N	High Blood Pressure	Y	N	Ulcers	Y	N
Diabetes	Y	N	High Cholesterol	Y	N	Varicose Veins	Y	N
Emphysema	Y	N	Kidney Disorder	Y	N	Weakness or Paralysis	Y	N
Epilepsy/Seizures	Y	N						

Please list any major or chronic illnesses not listed above: ☐ NONE

____

____

____

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Family History

Please Circle "Y" or "N" for any conditions YOUR FAMILY suffers from:

			FAMILY MEMBER				FAMILY MEMBER
Anemia	Y	N		Hepatitis	Y	N	
Asthma	Y	N		High Blood Pressure	Y	N	
Blood Clots	Y	N		High Cholesterol	Y	N	
Blood Transfusion	Y	N		Kidney Disorder	Y	N	
Cancer - Breast	Y	N		Liver Disease/Jaundice	Y	N	
Cancer - Colon	Y	N		Multiple Sclerosis	Y	N	
Cancer- Other: _________	Y	N		Problems with anesthesia	Y	N	
Colon/Rectal Polyps	Y	N		PVD (peripheral vascular dis)	Y	N	
Diabetes	Y	N		Rheumatic Fever	Y	N	
Emphysema	Y	N		Stroke	Y	N	
Gall Bladder	Y	N		Thyroid Disorder	Y	N	
Heart Attack /Surgery or Stents	Y	N		Tuberculosis	Y	N	

SOCIAL HISTORY:

Who lives in your home?____

Occupation: ____________________________ ☐ Full-Time ☐ Part-Time ☐ Student ☐ Retired

- Are you currently working? ☐YES ☐NO-Last day: __________ ☐ Unemployed ☐ Disabled
  - Reason not working:____
- Do you smoke? ☐YES ☐NO *How Much?* _____ Per Day *For How Long?* _____
- Have you quit? ☐YES ☐NO *When?* ____________________
- Do you drink over six cups of caffeinated beverages per day? ☐YES ☐NO
- Do you Drink Alcohol? ☐YES ☐NO
  - ***How much?*** ☐Weekly ☐Daily ☐Monthly ☐Rarely

FOR WOMEN ONLY:

At what age did you start having periods?____

Are you still having regular menstrual periods?____________________________________

Are you or have you ever been on hormone replacement therapy? ☐YES ☐NO

How many times have you been pregnant?____

Do you think you may currently be pregnant? ☐YES ☐NO

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Have you had any miscarriages? ☐NO ☐YES If so, how many?____________

How many children do you have?____

Your age at the time of your first pregnancy:____________________________________

When was your last mammogram?__________ ☐ Normal ☐ Abnormal

Where was your last mammogram?_____________________________________

FOR MEN ONLY:

Have you had a prostate exam? ☐NO ☐YES
If so, When? ____________________

Have you had a PSA (Prostate specific antigen) test? ☐NO ☐YES
If yes, when______________________ PSA Level_________________

The above information is completed to the best of my knowledge

____ **Patient Name**:________________________

Patient Signature **Date**

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CURRENT MEDICATION LIST

Patient Name: ________________________ Date: ____________________________

ALLERGIES	REACTION

PHARMACY	CROSS ROADS	PHONE NUMBER

PRESCRIPTION/OVER THE COUNTER MEDICATION NAME	DOSAGE	FREQUENCY	ROUTE/TOPICAL SITE

HERBAL MEDICATION NAME	DOSAGE	FREQUENCY	ROUTE/TOPICAL SITE

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Medicare Billing Authorization

Patient Name(Please Print)	Medicare Number
Secondary Insurance	Insurance ID/Group Number
Third Insurance	Insurance ID/Group Number

I request that payment of authorized Medicare benefits or my health insurance benefits be made either to me or on my behalf to **Columbia Surgical Associates, Inc.** for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Centers of Medicare and Medicaid Services (formally Health Care Financing Administration) and its agents, or other insurance carrier as directed by me, any information needed to determine these benefits payable for related services.

I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from this provider.

Signature	Date Signed