THE SURGICAL CLINIC

Patient Account #

Medical Questionnaire

Date of appointment: _____

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Referring Provider: _____ **Primary Care Provider:** _____

What problem are you being seen for today?
Describe your symptoms?
When did your symptoms begin?
How long do they last?
What makes them worse?
Does anything make them better?
Pain on a scale of 1 (= no pain) to 10 (= unbearable)? #:
Have you been treated for this before? When? By whom?

MEDICAL HISTORY: Are you under treatment for or have you been treated for any of the following? :		
☐ Anesthesia Problems	☐ Respiratory Problems	☐ Lung problems
☐ Diabetes	☐ Kidney problems	☐ Vascular problems
☐ Liver problems	☐ Heart problems	☐ High cholesterol
☐ Stroke	☐ Cancer/Kind	☐ High blood pressure
☐ Hepatitis	☐ Bleeding Problems	☐ Other

Have you ever had surgery? **If yes, please list below:**			
Date of Surgery	**Type of Surgery**	**Location/ hospital**	**Complications**

What medications are you sensitive to or allergic to?	**How does your body react to taking it?**
1)	Reaction:
2)	Reaction:

What medications and/or supplements do you take?	**Why do you take them?**	**What strength & how often?**
Pharmacy: **Phone:**	**Address:**	

MEDICAL ASSISTANT WILL FILL OUT THIS INFORMATION:

Pulse: _____ O2 Sat Rate: _____ Blood Pressure: R: _____/_____ L: _____/_____

Height: _____ Weight: _____

DIALYSIS PATIENTS ONLY: Please provide treatment information below.
Dialysis Days (Circle days): Monday Tuesday Wednesday Thursday Friday Saturday Sunday
Dialysis Times:
Facility Name:
Location:

Do you have a family history of? (Circle all that apply)

Stroke	Diabetes	Heart Disease	High Blood Pressure	Cancer
Father	Father	Father	Father	Father
Mother	Mother	Mother	Mother	Mother
Sister	Sister	Sister	Sister	Sister
Brother	Brother	Brother	Brother	Brother
Grandfather	Grandfather	Grandfather	Grandfather	Grandfather
Grandmother	Grandmother	Grandmother	Grandmother	Grandmother
Aunt	Aunt	Aunt	Aunt	Aunt
Uncle	Uncle	Uncle	Uncle	Uncle
Cancer – If so what type of cancer?				
Tobacco use (includes snuff, cigars, chewing tobacco, cigarettes, etc.)				
☐ Yes		☐ Not now		☐ Never
Indicate usage: (packs/day, cigarettes/day, cans of snuff/day, etc.)				

Marital Status	☐ Married	☐ Single	☐ Separated	☐ Divorced	☐ Widowed
Who lives with you?					
Your occupation?					

Alcohol use:	☐ Yes	☐ Not now	☐ Never
How much, how often?			
Drug use:	☐ Yes	☐ Not now	☐ Never
Type and frequency?			

WOMEN ONLY:		Date of Last Menstrual Period _____	Date of last pap smear? _____	
PREmenopausal Yes ☐ NO	POSTmenopausal Yes ☐ NO	Are you pregnant? Yes ☐ NO	Could you be pregnant? ☐ Yes No ☐	Date of last mammogram/results

Please check any box below that applies to you now or in the past 6 months:

☐ Good General Health	☐ Nausea/Vomiting	☐ Coughing up blood	☐ Blood in urine
☐ Recent Weight Change	☐ Abdominal pain	☐ Wear glasses/contacts	☐ Kidney stone
☐ Night sweats	☐ Rectal bleeding	☐ Blurred/double vision	☐ Sexual problems
☐ Fever	☐ Bowel problems	☐ Eye Disease or Injury	
☐ Fatigue	☐ Hearing loss	☐ Glaucoma	**MEN:**
☐ History of MRSA	☐ Ears ringing	☐ Change in hair or nails	Date of last prostate exam?
☐ Chest Pain	☐ Sinus problems	☐ Rash/itching	
☐ Palpitations	☐ Nose bleeds	☐ Insomnia	**EVERYONE:**
☐ Heart Problems	☐ Sore throat	☐ Confusion	Date of last stool study?
☐ Swelling hands/feet	☐ Voice change	☐ Memory loss	
☐ Excessive Thirst	☐ Muscle Pain/Cramps	☐ Depression	Date of last colonoscopy?
☐ Frequent Urination	☐ Stiffness/Swelling Joints	☐ Frequent Headaches	
☐ Thyroid Disease	☐ Joint pain	☐ Paralysis or Tremor	Date of flu shot?
☐ Hormonal problems	☐ Trouble walking	☐ Convulsions or Seizures	
☐ Easily Bruised	☐ Shortness of breath	☐ Tingling or Numbness	
☐ Slow to heal	☐ Cough	☐ Breast lump	
☐ Enlarged Glands	☐ Wheezing/Asthma	☐ Breast pain or discharge	

To the best of my knowledge, the above information is accurate and complete:

_____ _____

Patient's (or authorized person's) signature *Date*

_____ Information Updated & Reviewed by: _____

Physician *TSC Staff*

Patient Profile

Date: **Doctor you are seeing today:**

Account number		SSN	
Patient Name		DOB	
Address		City/State/Zip Code	
Home Phone		Cell Phone	
Work Phone		E Mail Address	
Marital Status		Gender	
Employer		Employer Address	
Referring Dr.	Dr.	Referring Phone	
PCP Name	Dr.	PCP Phone	
Pharmacy Name		Pharmacy Phone	

Preferred Language: _____ **Interpreter Needed:** Yes: __ No: __

Ethnicity: Hispanic: __ Not Hispanic: __

Race: Asian __ Black or African American __ Hispanic __ White __ Native Hawaiian or other Pacific Islander __ Other __

Are you currently living at any of the following facilities? *If YES, please choose one.*

Skilled Nursing: ___ Hospice: ___ Rehab Facility: ___ Other: ___

Do you have an Advanced Will Directive, Living Will, Living Trust, or Power of Attorney? Yes: ___ No: ___

Emergency Contact Information
Name: Phone: Relationship:

Primary Insurance Information
Name: Subscriber Name:
Subscriber number: Subscriber DOB:
Relationship to Patient:
Subscriber Employer: _____ Subscriber SSN: _____

Secondary Insurance Information
Name: Subscriber Name:
Subscriber Number: Subscriber DOB:
Relationship to patient:
Subscriber Employer: _____ Subscriber SSN: _____

The Surgical Clinic will file your insurance or collect self pay accounts. You, the patient will be responsible for any personal balances. Any account turned to an outside collection agency will accrue additional fees on the unpaid balance including any attorney/court cost in collecting that balance.

_____ _____
Patient Signature *Date*

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ **Account Number: _____**

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVICE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE or CONSENT FOR DATA TO BE EXCHANGED ELECTRONICALLY BETWEEN PROVIDERS/HOSPITALS**

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgement or Consents

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA?

_____ First Name Only _____ Proper Sur Name Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION and INFORMATION ABOUT MY HEALTH** VIA

Choose Only One Point of Contact

Home Telephone Number
(____)_____

_____ OK to leave message with detailed information
_____ Leave message with call back numbers only

Cell Number
(____)_____

_____ OK to leave message with detailed information
_____ Leave message with call back numbers only
_____ OK to send a text with detailed information

Work Telephone Number
(____)_____

_____ OK to leave message with detailed information
_____ Leave a message with call back numbers only

Office Use Only

I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment ___
- I could not communicate with the patient ___
- The patient refused to sign ___
- The patient was unable to sign ___
- Other (please describe) _____

Signature of TSC Staff Member _____

Patient Authorization Form

Please use blue or black ink to fill out this form and sign below.

Patient Name:_____ **Date of Birth:** _____ **Date:** _____

Because of the changes made by Congress, we are required to get your explicit permission regarding how your medical information is handled. You may request a copy of the Notice of Privacy Practices from our staff. Please read each authorization carefully and indicate your approval by initialing on the line provided.

- I authorize the release of all medical records maintained by The Surgical Clinic, PLLC, which relates to services I have received from, or the results of tests ordered by The Surgical Clinic, PLLC. These records may be released as needed for my care for the processing of insurance claims, to satisfy the requirements of a managed care organization of which I am a member, and/or to my attorney regarding pending or anticipated litigation under a worker's compensation, motor vehicle accident, and/or third party liability claim.

- I am giving permission for The Surgical Clinic and its sub-specialties (listed below) to obtain my prior films, scans, labs, and any records including demographic, pharmacy and medication history that may identify me and that relates to my past, present, and/or future physical or mental health or condition and related health care services . I understand that it is my responsibility to obtain previous studies, if asked to do so. If it is necessary for an employee of The Surgical Clinic to obtain my prior films, labs, and/or other records, I am giving my permission to call and/or fax on my behalf in order to get needed medical records and films.

- I authorize direct payment of benefits from my insurance plan to The Surgical Clinic, PLLC. I understand that I am responsible for payment of professional fees charged by the Surgical Clinic, PLLC, which are not covered or not properly reimbursed under the terms of my insurance plan.

  The Surgical Clinic, PLLC, will file your insurance or collect self-pay accounts. You, the patient, will be responsible for any personal balance. Any account turned to an outside collection agency will accrue additional fees on the unpaid balance including any attorney/court costs in collecting that balance.

- I will provide The Surgical Clinic, PLLC, with the phone numbers I authorize to be used to contact me. I authorize the use of any messaging person or system, voice mail and/or answering machine to convey information regarding my care. Contact via e-mail is authorized, if I provided my e-mail address to The Surgical Clinic.

- I authorize the use of fax or e-mail to send my information to myself or other parties that have a right to receive my information. I understand that every effort is made to protect my privacy, however, no absolute privacy guarantee is given when faxes or e-mails are used.

- I understand that it is my right to request limited access to my records and to withdraw permission for the release of my records. I understand that this request must be in writing and that limiting or withdrawing my permission may result in the Surgical Clinic, PLLC, discontinuing its relationship with me. In that case, I will need to seek care from another source.

Signature: _____ Date: _____

I have been offered a copy of The Surgical Clinic's Notice of Privacy Practices for my own records. Initials: _____

My signature above also gives my permission and consent for any and all medical information maintained in or generated by The Surgical Clinic on my behalf to be released and/or discussed with the following person(s):

_____ _____ _____ _____

Patient's family member's name *Relationship* *Patient's family member's name* *Relationship*

THE SURGICAL CLINIC FINANCIAL POLICY

Patient Name:
Patient Account:

We would like to thank you for choosing us to provide healthcare to you and your family.

INSURED PATIENTS: You must provide Proof of Insurance at your visit. Copays, deductibles and co-insurance are your responsibility. Your appointment may be rescheduled if not paid. If we are Out of Network with your insurance, you may be responsible for higher deductibles, copays, and coinsurance.

SELF PAY OR UNINSURED PATIENTS: A **$250.00 deposit** toward your office services is required the day of your first appointment at The Surgical Clinic. Your appointment may be rescheduled if not paid. If we are Out of Network with your insurance, you may be considered self-pay.

ESTIMATE FOR SURGERY: A **$650.00 deposit will be required prior to your surgery.**
A Financial Counselor can provide an estimate to you about the cost of your surgery.
This is just an estimate and may not be the final cost.

VEIN CENTRE, LETT PLASTICS & GARZA PLASTICS: Ask the Office Manager at these locations for other cash payment arrangements.

ASSISTANCE: Ask our Financial Counselor for payment options.

QUESTIONS? Call 615-292-5722, Option 1. We will be glad to help you!

****** We take Cash, Checks, Money Orders, and all Major Credit Cards******