

**PATIENT MEDICAL HISTORY**

DEAN CURRIE, MD    DAVID LAIRD, MD    DAVID VILLARREAL, MD    DANIEL DAY, MD

PATIENT NAME: \_\_\_\_\_ CHART: \_\_\_\_\_

DATE: \_\_\_\_\_ UPDATES: \_\_\_\_\_ DOB: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

Do you have a Living Will or Durable Power of Attorney? YES \_\_\_ NO \_\_\_

Would you like information regarding living wills? YES \_\_\_ NO \_\_\_ (PACKET GIVEN) \_\_\_\_\_

FAMILY DR: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_ City \_\_\_\_\_

Alternative contact (not living with you): \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Social History**

Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_ How many years? \_\_\_

Do you drink alcohol? \_\_\_\_\_ How much? \_\_\_\_\_ How often? \_\_\_\_\_

Occupation \_\_\_\_\_ Marital Status  S  M  D  W

PHARMACY NAME/LOCATION & NUMBER: \_\_\_\_\_

SIGNATURE OF PERSON COMPLETING FORM: \_\_\_\_\_

DO YOU TAKE ANY MEDICATIONS (INCLUDING OVER-THE-COUNTER) YES \_\_\_ NO \_\_\_

LIST ALL MEDICATIONS FREQUENTLY USED! (HORMONES, ASPIRIN PRODUCTS, INSULIN, ETC)

MEDICATION	DOSAGE MG/ML	NUMBER OF PILLS	NUMBER OF TIMES TAKEN

ARE YOU ALLERGIC TO ANY DRUGS? YES \_\_\_ NO \_\_\_ (PLEASE LIST)

\*Drug

\*Reaction


	YES	NO	
<b>Heart Disease</b>			
Coronary Artery Disease (Stents / Bypass/ Angina)			
Heart Attack (Myocardial Infarction)			When?
Congestive Heart Failure			
Valvular Disease			
Abnormal Heart Rhythm (Cardiac Arrythmias)			
<b>Stroke</b>			When?
<b>Kidney Disease</b>			
Stones			
Kidney Failure/Insufficiency			When diagnosed?
<b>Lung Disease</b>			
Emphysema (COPD)			
Asthma			
Bronchitis			
Cancer			
<b>Cancer</b>			
What type?			
Treatment given?			
<b>HIV</b>			When diagnosed?
<b>DIABETES</b>			When diagnosed?
<b>HIGH BLOOD PRESSURE (HYPERTENSION)</b>			
<b>GASTROINTESTINAL</b>			
Diverticulitis			
Colitis			
Ulcers			
Gallstones			

**List other diseases not mentioned above**


**Previous surgery/dates**

**Previous surgery/dates**


**Family History**

Have any of your family members had any of the following conditions?

(PLEASE LIST ALL THAT APPLY)

CANCER (Who/Relationship)	WHAT TYPE?
HEART DISEASE –Who	STROKE –Who
HYPERTENSION-Who	DIABETES-Who

## FREQUENT OR CURRENT SYMPTOMS OR PROBLEMS THAT YOU HAVE. CHECK YES OR NO

	YES	NO	
<b>General</b>			
Fever			
Night sweats			
Weight loss			How much?
Weight gain			How much?
Fatigue			
Loss of appetite			
<b>Cardiovascular</b>			
Chest pain			
Abnormal heart beat			
Shortness of breath			
At rest			
With exercise			
Wake you at night			
Sleep with head elevated on more than one pillow.			
Fainting Spells			How often?
Leg swelling			
Pain in legs upon walking			How far?
<b>Respiratory</b>			
Cough			
Sputum production			
Wheeze			
Bloody Sputum			
<b>Gastro-Intestinal</b>			
Abdominal Pain			
Nausea			
Vomiting			
Diarrhea			
Difficulty swallowing			
Constipation			
Blood in stool			
Heartburn			
<b>Genito-Urinary</b>			
Painful urination			
Frequency/urgency			
Controlling bladder			

	YES	NO	
Blood in urine			
Difficulty urinating			
Urinating after bedtime			How many times?
<b>Musculoskeletal</b>			
Muscle pain			
Joint pain			Where?
Joint stiffness			Where?
Joint swelling			Where?
<b>Skin</b>			
Rash			Where?
Changes in skin			Where?
<b>Neurological</b>			
Headaches			
Visual Changes			Describe?
Numbness			Where?
Weakness			Where?
Dizziness			
Loss of balance			
Mini-Stroke			When?
<b>ENT</b>			
Earache			
Hearing loss			
Sore throat			
Hoarseness			
Painful swallowing			
<b>ENDO</b>			
Intolerance to heat			
Intolerance to cold			
Change in hair			
Change in skin			
Trembles			
Shakes			
Hot flashes			

Patient Name: \_\_\_\_\_ Acct#: \_\_\_\_\_

CURRIE

VILLARREAL

LAIRD

DAY

**DISCLOSURE OF PROTECTED HEALTH INFORMATION FORM**

**Jackson Surgical Associates, PA**, may disclose personal health information about you to your family, close personal friends or another person that you identify as long as the information disclosed to those individuals is relevant to their involvement in your care, or the payment of your care. This Practice also may notify a family member or another person who is responsible for your care of your location and general health condition. This form provides you with the opportunity to choose not to have your health information disclosed to individuals involved in your care.

Please initial one of the following to indicate your choice regarding such disclosures:

\_\_\_\_\_ **I do not object** to my personal health information being disclosed to a family member, friend or another individual involved in my care.

\_\_\_\_\_ **Only** disclose my personal health information to the following person(s).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ **I object** to my personal health information being disclosed to a family Member, friend or another individual involved in my care.

\_\_\_\_\_  
Patient name (please print)

\_\_\_\_\_  
Signature of patient or representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship of patient representative to patient

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

I have received a copy of the Notice of Privacy Practices for Jackson Surgical Associates, PA. This notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the notice by calling 731-664-7395 or by requesting one at this office.

\_\_\_\_\_  
**Name of Patient (Please print)**

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Patient Representative (if patient is a minor or an adult who is unable to sign this form)**

\_\_\_\_\_  
**Relationship of Patient Representative to Patient**

-----

**Attempt to Obtain Acknowledgement**

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices on \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_. The acknowledgement was not obtained because:

The patient was undergoing emergency treatment.

The patient declined to sign the acknowledgement

The patient was initially seen at the hospital.

Other: \_\_\_\_\_

Name of Patient: \_\_\_\_\_

Name of Staff Member: \_\_\_\_\_

Date: \_\_\_\_\_

JACKSON SURGICAL ASSOCIATES

PLEASE PRINT

Name: \_\_\_\_\_ SS# \_\_\_\_\_

Address: Street \_\_\_\_\_ PO Box \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Martial Status: M  S  D  W

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Email: \_\_\_\_\_

Employer Name/Address/Phone: \_\_\_\_\_

Spouse: \_\_\_\_\_ Employer: \_\_\_\_\_

Family Doctor: \_\_\_\_\_

PRIMARY INSURANCE INFORMATION

Insurance Company: \_\_\_\_\_ Copay: Y  N  S \_\_\_\_\_

Insured Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

SS# of insured: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

SECONDARY INSURANCE INFORMATION

Insurance Company: \_\_\_\_\_ Copay: Y  N  S \_\_\_\_\_

Insured Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

SS# of insured: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

OTHER INSURANCE INFORMATION

Insurance Company: \_\_\_\_\_ Copay: Y  N  S \_\_\_\_\_

Insured Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

SS# of insured: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**RESPONSIBLE PARTY OR GUARDIAN IF PATIENT IS MINOR**

Name: \_\_\_\_\_ SS# \_\_\_\_\_

Address: Street \_\_\_\_\_ PO Box \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_

Employer Name/Address/Phone: \_\_\_\_\_

ALTERNATE CONTACT: \*not living with you

Address & Phone #: \_\_\_\_\_

## FINANCIAL POLICY

In order to establish a complete understanding of the financial responsibilities associated with the care provided by JACKSON SURGICAL ASSOCIATES, the financial policies are outlined for your review. If you have any questions, please feel free to ask for clarification.

It is our desire that you receive the maximum benefit from your health insurance. In order to achieve this, we need your assistance in providing complete and accurate personal and insurance information requested on our registration form.

For patients with an insurance plan with which we participate, we will submit a claim to your insurance company but require payment of any unpaid deductible, co-payment or coinsurance for services provided in the office at the time services are rendered. In the event your insurance company denies payment for services, the responsibility for full payment rests with the patient. For patients with an insurance plan with which we DO NOT participate, we require payment in full at the time services are rendered. We accept cash, check, money order, MasterCard, Visa, Discover and American Express. Returned checks are subject to a \$20.00 processing fee.

For outpatient or inpatient surgical procedures we require payment of any unpaid deductible and applicable coinsurance on your first post-operative office visit. We will submit a claim to your insurance company for any covered services, however, the patient is responsible for any remaining balance within 30 days after insurance payment is received. If you find that your insurance plan does not cover certain services or pays below our usual charge, we encourage you to discuss such issues with your insurance carrier. Any services not covered by insurance are to be paid in full prior to surgery.

We will provide medical care within your insurance contract guidelines if you inform us at the time of service exactly what guidelines apply. Often pre-approval or pre-certification for certain services are required so there may be a delay if we are unable to obtain approval from your insurance company immediately. If you do not inform us of any special requirements in your contract and we order or provide services which are not covered, you will be billed directly for those charges and payment is your responsibility. If you do not have insurance, all charges will be your responsibility and **will be due at the time of service.**

You are responsible for informing us if your insurance has any special requirements such as pre-certification, admission to a specified hospital, second surgical opinion or a referral from your primary physician. If a referral is required under your insurance plan, it is the patient's responsibility to obtain the necessary referral.

Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims and reduction or rejection of your insurance claim does not relieve the financial obligation you have incurred. Please remember that the ultimate responsibility for full payment including any collection fees or late charges for our services is the responsibility of the patient or guarantor.

I have read and understand this financial policy and agree to accept responsibility as described.

RESPONSIBLE PARTY SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**MEDICARE:** I request that payment of authorized benefits be made either to me or on my behalf to Jackson Surgical Assoc. for any services furnished me by that physician. I authorize any holder of medical information about me to release to HCFA & its agents any information needed to determine these benefits or benefits payable for related services.

**COMMERCIAL:** I hereby authorize JSA to submit a claim to my insurance carrier for all covered services rendered by JSA & direct my insurance company to issue payment directly to JSA. I authorize the release of medical or other information necessary for treatment, payment and health care operations. I authorize JSA to request my credit information. I understand that I am financially responsible for any balance that is not paid or covered by my insurance.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_