United Surgical Associates
Of Kansas City
Patient History

Demographics: Please fill out completely

Name First: _____ Last: _____ MI: _____
Date of Birth_____ Gender: **Male** **Female** SSN: _____
(Please Circle) Married Single Employed Unemployed Disabled Student
Ethnicity (Please Circle) Caucasian African American Arabic Hispanic Asian Other

Address Information:
Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone: Home: _____ Cell: _____
Is it ok to leave a message on your home phone? Y N
On your cell phone? Y N **E-Mail Address:** _____

Employment Information:
Employer: _____
Occupation: _____ Work #: _____

Insurance Information:
Insurance Company: _____Policy #: _____
Group #: _____ Policy Holder Full Name: _____
Policy Holder DOB: _____ Policy Holder SSN: _____
Relationship to Insured: _____ Insured Employer: _____

Referring Physician: _____ **Primary Care Physician** _____
How did you hear about us? Friend Internet Other family member

Social History: (please circle)
Tobacco Use: Y N **Alcohol:** Y N **Substance Abuse:** Y N

Preferred Pharmacy: _____

Emergency Contact: _____

Past Medical History: *Please list (for example: High blood pressure)*

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Surgical/Hospitalization History: *Please list any/all surgeries or hospitalizations.*

_____Month:_____Year:_____
_____Month:_____Year:_____
_____Month:_____Year:_____
_____Month:_____Year:_____
_____Month:_____Year:_____
_____Month:_____Year:_____

Family History: *Please indicate relationship*

Heart Disease _____ High Blood Pressure _____
Sleep Apnea _____ Diabetes Mellitus _____
GERD _____ Depression _____
Obesity _____ Mental Illness _____
Bleeding Disorders _____ Cancer _____

Current Medications: *Please List*

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Drug/Medication Allergies: *Please list and type of reaction*

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Skin allergies: *Please list and type of reaction*

_____ _____ _____
_____ _____ _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment here at United Surgical Associates is to serve our patients with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Healthcare Information.

During the course of serving your interests it may be necessary to share information with other health care providers or insurance companies. The following are examples of instances where information may be shared.

To acquire or send medical records, workman's compensation claims, and for information to be sent to your referring physician.

We here at United Surgical Associates are committed to obeying all Federal, State and Local laws and regulations regarding privacy practices. If any other purposes or requests arise information will be only released by written authorization of the individual in question or authorized Power of Attorney.

If you have any questions regarding your Professional Health Information, feel free to contact our Compliance Officer at 816-254-9292

I have read and understand the above Notice of Privacy Practices.

Signature _____Date_____

By signing on the line provided below you are giving United Surgical Associates permission to retrieve your medication history.

Signature_____Date_____

In the space given below please list anyone we may discuss your medical care with.

_____

_____