United Surgical ASSOCIATES of Kansas City

Demographics: Please fill out completely

Name First: _____ Last: _____ MI: _____
Date of Birth_____ SSN: _____
Gender: (Please Circle) Male Female
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? Yes No
On your cell phone? Yes No 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** _____

Preferred Pharmacy: _____

Emergency Contact: _____

Social History:

Marital Status (circle one) Single Married Separated Divorced Widowed

Tobacco (circle one) Current Former Never

If Current or Former: Number of cigarettes per day: _____

Number of years smoked: _____

Alcohol (circle one) Current Former Never

If Current or Former: Number of drinks per day/week: _____ Type: _____

Drugs (circle one) Current Former Never

If Current or Former: Type of drug: _____

Number of years used: _____

Medical History: *Circle Yes or No*

			Comments
Arthritis	Yes	No	_____
Asthma	Yes	No	_____
Blood transfusion	Yes	No	_____
Chronic lung disease	Yes	No	_____
Cancer	Yes	No	_____
Diabetes	Yes	No	_____
Eye disease	Yes	No	_____
Heart disease	Yes	No	_____
Hypertension	Yes	No	_____
Kidney disease	Yes	No	_____
Liver disease	Yes	No	_____
Psychiatric disorder	Yes	No	_____
Seizures/epilepsy	Yes	No	_____
Stomach/intestinal disease	Yes	No	_____
Stroke	Yes	No	_____
Thyroid disease	Yes	No	_____
Other	Yes	No	_____

Surgical History

List any surgeries you have had and the approximate date. Example: tonsillectomy, appendectomy, gallbladder removal, tubal ligation, breast surgery/biopsy, laparoscopy.

_____

_____

_____

Family History:	*Circle Yes or No*	*Family relationship to you*
Heart Disease	Yes No	_____
Sleep Apnea	Yes No	_____
GERD	Yes No	_____
Obesity	Yes No	_____
Bleeding Disorders	Yes No	_____
High Blood Pressure	Yes No	_____
Diabetes Mellitus	Yes No	_____
Depression	Yes No	_____
Mental Illness	Yes No	_____
Cancer		
Breast	Yes No	_____
Ovarian	Yes No	_____
Colon	Yes No	_____
Other	Yes No	_____
Other	Yes No	_____

Current Medications:

Name	Dosage	How often do you take it?	Date started?

Medication Allergies

Medication	Type of reaction

Skin Allergies

Allergy	Type of reaction

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

Our commitment here at United Surgical Associates is to serve our patients with professionalism and care, 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.

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

MEDICAL INFORMATION AUTHORIZATION

☐ ***I DO NOT** authorize the physician or anyone associated with his/her group to discuss my medical condition, treatment or test results with anyone other than myself.

☐ ***I DO** authorize the physician or anyone associated with his/her medical group to discuss my medical condition, treatment and test results with the following people (family/friends, not to include physicians):

Name	Phone	Relationship
Name	Phone	Relationship
Name	Phone	Relationship

Signature of patient or legal representative — Date

Printed name of patient/legal representative — Relationship