***Please fill out completely***

**Name** First: ________________ Last: ______________________ MI: ____________
Date of Birth________________ SSN: ______________________
Gender: Male___ Female___
**Ethnicity** 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 #: _________________________

**Is your visit related to a Workman's Comp injury?** Yes___ No___
Carrier: _____________________________ Case #:___________________________
Contact: _____________________________ Phone #: _________________________

**Insurance Information** (Primary)**:**
Insurance Company: ________________________Policy #: ____________________
Group #: _________________ Policy Holder Full Name: _______________________
Policy Holder DOB: _______________ Policy Holder SSN: ______________________
Relationship to Insured: ____________ Insured Employer: _____________________

**Insurance Information** (Secondary)**:**
Insurance Company: ________________________Policy #: ____________________
Group #: _________________ Policy Holder Full Name: _______________________
Policy Holder DOB: _______________ Policy Holder SSN: ______________________
Relationship to Insured: ____________ Insured Employer: _____________________

**Your insurance card and photo ID will need to be provided at the time of your appointment.**

**Referring Physician**: ____________________________________________

**Primary Care Physician:** __________________________________________

**Preferred Pharmacy:** ____________________________________________

**Emergency Contact Name:**________________________________________

**Emergency Contact #:**___________________________________________

**Social History:**

Marital Status: Single___ Married___ Separated___ Divorced___ Widowed___

Tobacco Use: Current___ Former___ Never___

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

Number of years smoked: _______

Alcohol Use: Current___ Former___ Never___

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

Type: ____________________________

Recreational Drug Use: Current___ Former___ Never___

If Current or Former: Type of drug: ____________________________

Number of years used: _______

## Medical History:

*Comments*

Arthritis Yes___ No___ ________________________________
Asthma Yes___ No___ ________________________________
Blood transfusion Yes___ No___ ________________________________
Cancer Yes___ No___ ________________________________
Chronic lung disease Yes___ No___ ________________________________
Diabetes Yes___ No___ ________________________________
Eye disease Yes___ No___ ________________________________
Heart disease Yes___ No___ ________________________________
Hypertension/Hypotension 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:

*Family relationship to you (other than 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? |
|---|---|---|---|
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## Medication Allergies

| Medication | Type of reaction |
|---|---|
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## Skin Allergies

| Allergy | Type of reaction |
|---|---|
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## 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

# DISABILITY, FMLA AND ATTENDING PHYSICIAN STATEMENTS

1. There is a $30.00 fee for completion of each form or statement.

   Fee Paid: Yes___ No___

2. We collect the above fee prior to returning, faxing or mailing your paperwork.

3. It is our goal to complete the paperwork as soon as possible. **Please allow 10 to 14 business days to complete your paperwork.**

| | |
|---|---|
| Name: | DOB: |
| Phone number where you can be reached: | Today's date: |
| Check how you want the paperwork returned:<br>__ pick up at office<br>__ fax to: (fax number) ____________________________<br>__ mail to: (complete address) ____________________________<br>____________________________ | |
| Have you read and signed a release to send records? Yes___ No___ | |
| What type of form(s) are we filling out?<br>__ FMLA __ Insurance<br>__ Short Term Disability __ Physician Statement<br>__ Long Term Disability __ Other ____________________ | |
| Have we filled out this type of paperwork for you before? Yes___ No___ | |
| Are we filling this paperwork out for a hospitalization and/or an illness? Please explain: | |
| What date did you and your physician determine you would return to work? | |
| Signature: | Date: |

# HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by ______________________________________________________

Printed Name (Patient or Representative)

The Consent was signed by ______________________________________________________

Signature (Patient or Representative)

Relationship to Patient (if other than patient): _____________________________________

Witness: __________________________________________________________

Printed Name (if Representative signed above)