



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?

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
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Name	Phone	Relationship
------	-------	--------------

Name	Phone	Relationship
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Signature of patient or legal representative	Date
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Printed name of patient/legal representative	Relationship
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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: ___ pick up at office ___ fax to: (fax number) _____ ___ mail to: (complete address) _____ _____	
Have you read and signed a release to send records? Yes___ No___	
What type of form(s) are we filling out? ___ FMLA _____ Insurance ___ Short Term Disability _____ Physician Statement ___ 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)