**Cahaba Valley Surgical Group, PC**

## *Patient Information Form*

| **Demographic Information:** | | | | **Chart#** | |
|---|---|---|---|---|---|
| **Last Name:** | | **First:** | | **Middle:** | |
| **Called By:** | | **Maiden:** | | | |
| **Date of Birth:** | | **Gender:** | F M U | **Soc. Sec. #** | |
| **Marital Status:** | M S W D Other | **Preferred Language:** | | **Race/Ethnicity:** | |
| **Address:** | | | | | |
| **Zip:** | | **City:** | | **ST:** | |
| **Phone #s** | **Home:** | | **Work:** | | **Cell:** |
| **Email:** | | **Preferred contact:** ❒ **Cell** ❒ **Home** ❒ **Work** ❒ **Mail** ❒ **Email** ❒ **Web portal** | | | |
| **Preferred Pharmacy City/St/Phone:** | | | | | |
| **Employer:** | | **Occupation:** | | **Phone:** | |
| **Spouse:** | | **Occupation:** | | | |
| **Financially Responsible Party:** | ❒**Self or list here:** | | | | |
| **Relationship:** | | **Contact Info:** | | | |
| **Billing Address:** | **Is your billing address different than the address above?** | | | | |
| **Insurance Information:** | **Do you have health insurance you want us to file?** | ☐ Yes ☐ No | | | |
| **Is this visit due to injury or accident?** | ☐No ☐ Yes | **Is this a worker's compensation claim?** | ☐ No ☐ Yes | | |
| **Insurance Co. #1** | | **Contract / ID #** | | **Group #** | |
| **Effective Date:** | | **Are you the** ☐Insured/Subscriber ☐Spouse ☐ Dependent **on this policy?** | | | |
| **List the name or subscriber of this policy EXACTLY as listed on the insurance card:** | | | | | |
| **Subscriber DOB:** | | **SSN:** | | | |
| **Insurance Co. #2** | | **Contract / ID #** | | **Group #** | |
| **Effective Date:** | | **Are you the** ☐Insured/Subscriber ☐ Spouse ☐ Dependent **on this policy?** | | | |
| **List the name or subscriber of this policy EXACTLY as listed on the insurance card:** | | | | | |
| **Subscriber DOB:** | | **SSN:** | | | |
| **Referrals:** | **Who is your referring physician?** | | **City/ST** | | |
| **Who is your primary physician (if different)?** | | | **City/ST** | | |
| **Privacy Notice:** | Please note that we maintain a **Notice of Privacy Practices**, which is posted at several locations in our waiting room. We also have copies that are accessible at the front desk that we encourage you to take and familiarize yourself. | | | | |

List any individuals with whom you give us permission to discuss your account and medical information, including but not limited to treatment, diagnosis, medications, test results or other types of protected health information in order to facilitate or coordinate treatment and payment for your services. You understand that the release of your information is voluntary and does not affect your access to treatment. You can choose NOT to disclose your information if you wish. You can revoke this authorization at any time by writing to Cahaba Valley Surgical Group, PC, or by filling out a new form.

| **Name** | | **Relationship** | | **Contact #** | |
|---|---|---|---|---|---|
| **Name** | | **Relationship** | | **Contact #** | |
| **Name** | | **Relationship** | | **Contact #** | |

The staff of Cahaba Valley Surgical Group, P.C. thank you for entrusting us with your healthcare. **Please read this statement carefully and sign at the bottom of this form.**

I acknowledge that I am presenting to this office for evaluation and treatment, which may include surgery, medications and diagnostic tests. I authorize the release of any medical, insurance or other information necessary to treat me and coordinate my care, to process claims on my behalf, and authorize Cahaba Valley Surgical Group to do so if I have indicated that I have insurance for my services. I assign benefits for payment of insurance claims directly to the practice. I agree to be fully responsible for all lawful debts incurred for services I receive from Cahaba Valley Surgical Group, P.C., as well as medical services provided in any hospital setting necessary, whether covered by my insurance or not, including any collections fees if I do not pay my bill. I understand that my insurance may have a deductible, coinsurance, non-covered services, and/or pre-existing condition provisions and I will be fully responsible for any patient responsibilities as indicated by my insurance company.

**Patient Signature** (or Guardian) ________________________________ **Date** _________

**Cahaba Valley Surgical Group, PC**

Chart #_________

## CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your private health and financial information is protected by federal and state laws. We are required to uphold specific standards to protect and secure that information. By presenting to our office and signing below, you hereby consent for Cahaba Valley Surgical Group, PC to use or disclose information about yourself (or another person for whom you have the authority to sign) for the sole purposes of treatment (coordinating, arranging and delivering care, including referrals to other healthcare providers for your treatment), payment (which may include filing claims or sending statements, including medical information to support processing claims) and health care operations. You may refuse to sign this consent form.

We maintain a Notice of Privacy Practices which is posted in our office, of which copies are available to you at our registration desk.

You have the right to request that the Practice restrict how protected health information (PHI) is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to requested restrictions; however; if the Practice agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

## AUTHORIZATION FOR COMMUNICATIONS

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Cahaba Valley Surgical Group, PC representative or my physician direct to me by mail, telephone, e-mail, or publish to a secure encrypted website (if I so indicate) communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Cahaba Valley Surgical Group, PC to that effect in writing.

## TREAMENT CONSENT

I hereby consent to evaluation, testing, and treatment as directed by my Cahaba Valley Surgical Group, PC. physician or his/her designee.

Acknowledged-

______________________________________ ______________________________

Signature Date

**Cahaba Valley Surgical Group, PC**

## *Medical Evaluation Form*

Patient Name ______________________________ Date of Birth _____/_____/_____ Age _____

Patient Height: _________ Weight _______ lbs. BMI _____ (Body Mass Index, if known) Today's Date: _____/_____/_____

Primary Care Physician: ____________________________ Specialist ( eg. Cardiologist) ____________________________
(Or Referring Physician)

**Reason for visit** (**chief complaint**): ______________________________________________

**Medical History**: ☐ (Or *None of these*) (Check or circle all that apply)

| | | | | |
|---|---|---|---|---|
| ☐ Alzheimer's | ☐ Colitis | ☐ Gout | ☐ Lung disease | ☐ Renal Failure |
| ☐ Anemia | ☐ Cholesterol | ☐ Heart Disease | ☐ Malignant hyperthermia | ☐ Seizures |
| ☐ Arthritis | ☐ Diabetes – Type I | ☐ Heart Failure | ☐ Mental illness | ☐ Sleep Apnea |
| ☐ Bleeding disorder | ☐ Diabetes- Type II | ☐ Hiatal hernia | ☐ Migraine headaches | ☐ Stomach ulcers |
| ☐ Blood Clots | ☐ Emphysema | ☐ Hypertension | ☐ Mitral valve prolapsed | ☐ Stroke |
| ☐ Blood transfusions | ☐ Enlarged prostate | ☐ Hypoglycemia | ☐ Parkinson's Disease | ☐ TB |
| ☐ Cancer | ☐ Gastric reflux | ☐ Heart valve | ☐ Post-Menopausal | ☐ Thyroid problems |
| ☐ Cataracts | ☐ Glaucoma | ☐ Intestinal problems | ☐ Poor Circulation (PVD) | ☐ LMP: ___/___ |
| | | ☐ Kidney stones | | |

☐ *Other* ______________________________________________

**Surgical History**: ☐ (Or *None of these*) (Check or circle all that apply and indicate the year)

| | | | | |
|---|---|---|---|---|
| ☐ Appendectomy__ | ☐ Carotid Endarterectomy__ | ☐ Gallbladder __ | ☐ Hysterectomy__ | ☐ Prostate__ |
| ☐ Amputation __ | ☐ Carpal tunnel__ | ☐ Gastric banding/stapling__ | ☐ Joint replacement__ | ☐ Reflux (Nissen) __ |
| ☐ Back__ | ☐ Cataract__ | ☐ Gastric bypass__ | ☐ Knee Arthroscopy__ | ☐ Stent Artery (heart/leg) |
| ☐ Bladder__ | ☐ Colon__ | ☐ Heart__ | ☐ Knee Replacement__ | ☐ Shoulder Surgery__ |
| ☐ Breast biopsy__ | ☐ Diagnostic laparoscopy__ | ☐ Hernia__ | ☐ Lung__ | ☐ Thyroid__ |
| ☐ Breast augmentation | ☐ D & C__ | ☐ Hemorrhoidectomy__ | ☐ Mastectomy__ | ☐ Tonsils__ |
| ☐ Cystoscopy__ | | | | ☐ Tubal Ligation__ |

☐ *Other* __ ______________________________________________

**Medications:** *please list all current* ***medications, dose/strength, and frequency taken****–please include supplements, vitamins,& herbs*

| *Name of Medication* | *dosage* | *freq* | *Name of Medication* | *dosage* | *freq* | *Name of Medication* | *dosage* | *freq* |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

★**Drug Allergies:** (please list drug and reaction) ______________________________________________

★**Other Allergies (**foods, pets, environmental)**:**______________________________________________

**Family History**: *please list illness in your family*

| Please indicate below significant medical problems of family members. Indicate which family members by checking (X) the appropriate column. | Mother | Father | Brother | Sister |
|---|---|---|---|---|
| Heart Disease | ☐ | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ |
| Cancer (Type) | ☐ | ☐ | ☐ | ☐ |
| Other: | ☐ | ☐ | ☐ | ☐ |

**Social History**: (*check or circle which best describes you*)

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other ☐ Employed (job description:__________) ☐ Unemployed ☐ Retired
☐ Student (grade/level ____________) ☐ Disability (due to ________________________

| **Substance Use** (check) | **Current** | **Past** | **Never** | **Comments** (frequency, amount, age started/stopped) |
|---|---|---|---|---|
| Alcohol Use | ☐ | ☐ | ☐ | |
| Tobacco Use | ☐ | ☐ | ☐ | |
| Illicit Drug Use | ☐ | ☐ | ☐ | |
| Smokeless tobacco | ☐ | ☐ | ☐ | |

**Cahaba Valley Surgical Group, PC**

**Are you currently experiencing….?** ***Medical Evaluation Form*** Chart #______

***Name:*** ________________________________

(Please check all that apply)

| | |
|---|---|
| **Constitutional / General** ☐ (Or *None of these*)<br>☐Weight gain ☐Weight loss<br>☐Fever ☐Chills ☐Fatigue ☐ Body aches | **Genitourinary (Urologic, GYN)** ☐ (Or *None of these*)<br>☐Blood in urine ☐Burning on urination ☐Pelvic pain<br>☐Difficulty voiding ☐Incontinence/wetting<br>☐Vaginal discharge ☐Abnormal uterine bleeding |
| **Eyes** ☐ (Or *None of these*)<br>☐Impaired vision ☐Blurred vision<br>☐Recent changes in vision | **Neurological** ☐ (Or *None of these*)<br>☐Headache ☐Light headed/dizzy ☐Seizure<br>☐Numbness ☐Tingling ☐Memory difficulties |
| **HENT (Ear, Nose Throat)** ☐ (Or *None of these*)<br>☐Hearing loss ☐Sore throat ☐Sinus drainage<br>☐Neck tenderness ☐Dental problems ☐Thyroid mass | **Musculoskeletal** ☐ (Or *None of these*)<br>☐Joint pain ☐Foot/leg ulcers ☐Muscle weakness<br>☐Muscle cramps ☐Back pain ☐Muscle Pain |
| **Breast** ☐ (Or *None of these*)<br>☐Breast pain ☐Breast lump ☐Nipple drainage<br>☐Breast Tenderness | **Endocrine** ☐ (Or *None of these*)<br>☐Cold intolerance ☐ Heat intolerance<br>☐Hair loss ☐Hot Flashes |
| **Cardiovascular (Heart)** ☐ (Or *None of these*)<br>☐Chest pain ☐Palpitations ☐Swelling in legs/feet<br>☐Varicose veins ☐Leg pain with walking | **Psychiatric** ☐ (Or *None of these*)<br>☐Depression ☐Anxiety ☐Abnormal stress<br>☐Difficulty sleeping ☐Impulsive Behaviors |
| **Respiratory** ☐ (Or *None of these*)<br>☐Cough ☐Coughing up blood ☐Shortness of breath<br>☐Asthma/wheezing ☐Sleep Apnea | **Hematologic / Lymphatic** ☐ (Or *None of these*)<br>☐Easy bruising ☐Easy bleeding<br>☐Lymph node enlargement |
| **Gastrointestinal** ☐ (Or *None of these*)<br>☐Nausea ☐Vomiting A☐bdominal pain ☐Reflux<br>☐Heartburn ☐Diarrhea ☐Constipation<br>☐Blood in stool ☐Mouth ulcers ☐Hemorrhoids | **Allergic / Immunologic** ☐ (Or *None of these*)<br>☐Sinus allergy symptoms ☐Allergic dermatitis<br>☐Frequent allergic illnesses |

Regarding the main reason you are here today, When did these symptoms begin? ______________________

How long do they last? ________________________________________ How severe? (check) 1 2 3 4 5 (Mild Mod. Severe) ☐ ☐ ☐ ☐ ☐

What treatment options have you tried? ________________________________________

Have you had any diagnostic tests for these problems ( labs, X-rays, etc.)?______________________________

**Reproductive History (Female Patients):**

**Menstrual History:** When was your last menstrual period? ______

Your age at first menstrual period?______ Age of menopause (if applicable)?______

**Obstetrical History:** # of Pregnancies _____ # of Miscarriages _____ # of Live Births _____