

Patient Information Please Fill Out Completely

****Please Submit ALL Insurance Cards to the Front Desk****

Patient Name: _____
(First) (Middle) (Last)

Birthday: _____ Age: _____ SS# _____ Marital Status: _____

Address: _____
(Street) (City) (State/Zip)

Home Phone: _____ Cell Phone: _____

Employer: _____

Work Phone: _____ Occupation: _____

Referring Doctor: _____ Family Doctor: _____

Reason for Today's Visit: _____

****Parent or Spouse Information****

Are you covered under your parent's or spouse's Insurance? _____

Name: _____ Birthday: _____

SS# _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

**** Contact Person In Case of Emergency**
(Someone Other Than Parent Above)**

Name: _____ Phone: _____ Cell: _____

**** Worker's Compensation****

Complete the following ONLY if your injury is work related

Company Name: _____ Supervisor: _____

Address: _____ Phone _____

Date of Injury: _____ Type of Injury _____

****I authorize the release of medical or other information necessary to process claims on my behalf. I authorize the release of my medical records to other physicians of necessary. I agree to be fully responsible for all lawful debts incurred by myself services received from Capital Surgical Clinic whether covered by insurance or not and hereby assign benefits thereto**

Patient's Signature: _____

Today's Date: _____

CAPITAL SURGICAL CLINIC, LLC

GENERAL, LAPAROSCOPIC, VASCULAR AND THORACIC SURGERY

STEVEN R. VALLANCE, MD, PhD, FACS
BRYAN A. SHOUSE, MD, FACS
TIMOTHY BOWLING, MD

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Capital Surgical Clinic originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Capital Surgical Clinic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Capital Surgical Clinic reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Capital Surgical Clinic change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

Patient's Signature

Date

FOR OFFICE USE ONLY

- Consent received by _____ on _____.
- Consent refused by patient, and treatment refused as permitted.
- Consent added to the patient's medical record on _____.

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Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Capital Surgical Clinic's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

These Questions Are Being Asked to Fulfill Our Commitment to Protect Your Privacy

1. Is there anyone other than you that we can discuss your medical information. Yes No
Name: _____
2. May we contact you at home to give test results, reschedule appointments, and/or discuss billing information? Yes No
3. May we leave a message at your home to give test results, reschedule appointments, and/or discuss billing information? Yes No
4. May we contact you at work to give test results, reschedule appointments, and/or discuss billing information? Yes No

If you are unavailable at work may we leave a voice message or with the person answering the phone?
Yes No

IF WE HAVE PERMISSION TO LEAVE A MESSAGE AT HOME OR WORK WE WILL BE IDENTIFYING OURSELVES AS WELL AS WHAT OFFICE WE ARE CALLING FROM.

Signed: _____ Date: _____

If not signed by patient indicate relationship to patient (e.g., spouse)

Relationship: _____ Witnessed by: _____

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): _____

By: (name and title): _____

HEALTH HISTORY

(Confidential)

Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

SYMPTOMS: Check (✓) symptoms you currently have or have had in the past year.

GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	MEN only
<input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	<input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent Cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision-Flashes <input type="checkbox"/> Vision Halos	<input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other
<p style="text-align: center;">MUSCLE/JOINT/BONE</p> <p>Pain, weakness, numbness in;</p> <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<p style="text-align: center;">CARDIOVASCULAR</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	<p style="text-align: center;">SKIN</p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal	<p style="text-align: center;">WOMEN only</p> <input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other
<p style="text-align: center;">GENITO-URINARY</p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination			Date of last Menstrual period _____ Date of last Pap Smear _____ Have you had a Mammogram? _____ Are you pregnant? _____ Number of children _____

CONDITIONS: Check (✓) conditions you have or have had in the past.

<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts	<input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio	<input type="checkbox"/> Prostate Problem <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal infections <input type="checkbox"/> Venereal Disease
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MEDICATIONS: List medications you are currently taking

ALLERGIES: To medications or substances

Pharmacy Name: _____ Phone _____

