ADVANCED SURGICAL ASSOCIATES, LTD.

Patient Forms

Seeing Doctor:_____ Date: _____/_____/_____

How did you hear about us?_____ O Male O Female

Who is your Primary Care Dr?_____

Patient Information

Patient Name_____ Date of Birth _____/_____/_____

Nickname_____ Marital Status:_____

Address_____

City_____ State_____Zip_____

Language_____ Race_____ Ethnicity_____Social Security #_____

(Primary) Phone: _____ O Home O Work O Other

(Secondary) Phone: _____ O Home O Work O Other

May we leave a voicemail with medical information? O Yes O No

Patient under 18? O Yes O No

(If yes, please fill out all that is below)

Guarantor's Name:_____

Phone Number:_____

Email Address

_____

Employer_____

Employer Phone #_____

Policy Holder Information O Same as Patient

Name_____

Date of Birth _____/_____/_____

SS/ID #_____

Relationship to paitent_____

Address (if Different from Patient)_____

_____

Is this work related? O Yes O No

Policy Id#_____

Claims Mailing Address _____

_____

Adjuster's Name _____

Adjuster's Phone_____

Primary Insurance (who is the policy holder?)

O Patient O Guarantor O Other

Insurance Company_____

ID#_____

Group #_____

Secondary Insurance (who is the policy holder?)

O Patient O Guarantor O Other

Insurance Company_____

ID#_____

Group #_____

I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay what I owe to this office upon request. If my account is referred to a collection agency, I agree to pay collection expenses including attorney's fees. My health insurance or other benefits relating to my medical condition are available to cover the cost for treatment provided by this office. I hereby assign those benefits to this office to be applied to my bill. A copy of this authorization shall be valid until rescinded in writing or replaced by one at later date.

Date: _____/_____/_____Patient/Guarantor's Signature: _____

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Name_____ DOB_____ Date_____

Medications: O **YES** (List Medications & over the counter supplements below) OR O **NO** (I do not take medications)		
Name Of Medicine	Dosage & How often taken	Reason for taking medication.

Allergies : O YES (List Below) O NO Allergies	Reaction

Surgical History: (Please list surgeries, hospitalizations) O None	**Dates**

Doctors: Please list all doctors currently involved in your care.		
Name	Phone #	Reason

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Family Medical History ☑	Mother	Father	Siblings	Paternal Grandmother	Paternal Grandfather	Maternal Grandmother	Maternal Grandfather
High Blood Pressure							
Lung Disease							
Bleeding Problems							
Diabetes							
Stroke							
Heart Disease							
Cancer (Specify what type)							
Other Family Members:							

Personal Social History					
Tobacco Use	O Never	O Quit/When	O Current Smoker/Packs Per Day:_____		
Alcohol Use	O Never	O Rarely	O Moderate	O Daily	
	How Much?				
Drug Use	O Never	Type/Frequency_____			
Occupation					

Past Medical History					
Anemia?	O Yes O No	**Depression?**	O Yes O No	**Kidney Stones?**	O Yes O No
Anxiety?	O Yes O No	**Gout?**	O Yes O No	**Pancreatitis?**	O Yes O No
Arthritis?	O Yes O No	**Heart Disease?**	O Yes O No	**Panic Attacks?**	O Yes O No
Asthma?	O Yes O No	**Heart Mummur?**	O Yes O No	**Rashes?**	O Yes O No
Bladder Infection?	O Yes O No	**High Blood Pressure?**	O Yes O No	**Rheumatic Fever?**	O Yes O No
Bleeding Problems?	O Yes O No	**Hepatitis?**	O Yes O No	**Seizures?**	O Yes O No
Blood Transfusion?	O Yes O No	**High Cholesterol?**	O Yes O No	**Stroke?**	O Yes O No
Cancer?	O Yes O No	**Infections?**	O Yes O No	**TB?**	O Yes O No
COPD?	O Yes O No	**Inflammatory Bowel Disease?**	O Yes O No	**Thyroid Disease?**	O Yes O No
Diabetes?	O Yes O No	**Obesity?**	O Yes O No	**Ulcer?**	O Yes O No
Other? O No O Yes (if yes explain)					
If Yes to cancer, What type?					

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Review of Symptoms					
General		**Endocrine**		**Gastrointestinal**	
Weight Gain	O Yes O No	Excessive thirst	O Yes O No	Nausea	O Yes O No
Weight Loss	O Yes O No	Thyroid disease	O Yes O No	Vomiting	O Yes O No
Fever	O Yes O No	Hormone problem	O Yes O No	Abdominal pain	O Yes O No
Fatigue	O Yes O No	**Musculoskeletal**		Rectal bleeding	O Yes O No
Change in appetite	O Yes O No	Leg Cramps	O Yes O No	Bowel problems	O Yes O No
Night Sweats	O Yes O No	Muscle Aches	O Yes O No	**Allergy/Immunology**	
Ophthalmologic		Joint Stiffness	O Yes O No	Food allergy	O Yes O No
Blurred Double Vision	O Yes O No	Swollen Joints	O Yes O No	Other	O Yes O No
Glasses/Contacts	O Yes O No	Joint Pain	O Yes O No	**Psychiatric**	
Glaucoma	O Yes O No	**Genitourinary**		Insomnia	O Yes O No
Eye Disease/Injury	O Yes O No	Kidney Stones	O Yes O No	Confusion/Memory loss	O Yes O No
ENT		Blood in urine	O Yes O No	Depression	O Yes O No
Ringing in the ears	O Yes O No	Testicle pain	O Yes O No	**Breast (Including Men)**	
Sore Throat	O Yes O No	Menstrual Problems	O Yes O No	Nipple Discharge	O Yes O No
Sinus Problems	O Yes O No	**Neurologic**		Breast Pain	O Yes O No
Decreased Hearing	O Yes O No	Tingling/Numbness	O Yes O No	Breast Lump	O Yes O No
Nose bleed	O Yes O No	Convuslions/Seizures	O Yes O No	**Women Only**	
Cardiovascular		Frequent headache	O Yes O No	**Are you Pregnant**	O Yes O No
Chest Pain at rest	O Yes O No	Paralysis/Tremor	O Yes O No	**If so, How far along?**	
Chest pain with exertion	O Yes O No	Loss of use of extremity	O Yes O No	O 1st Trimester O 2nd Trimester O 3rd Trimester	
Palpitations	O Yes O No	**Hematology**		**Number of pregnancies?**	
Heart Trouble	O Yes O No	Bruise Easily	O Yes O No	O 0-2 O 3-5 O More than 5	
Fluid accumulation in legs	O Yes O No	Slow to heal	O Yes O No	**Number of Deliveries**	
Respiratory		Enlarged glands	O Yes O No	O 0-2 O 3-5 O More than 5	
Shortness Of Breath	O Yes O No	**Skin**		**Did you breast feed?**	
Shortness of Breath with exertion	O Yes O No	Rash	O Yes O No	O Yes O No	
Wheezing/Asthma	O Yes O No	Itchy	O Yes O No	**If Yes, Are you currently Breast Feeding?**	
Coughing up blood	O Yes O No	Change in hair/nails	O Yes O No	O Yes O No	

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Patient Statement: To the best of my knowledge, the above information is accurate and complete and I acknowledge that I have been presented and read a copy of the Office Policies and The Practice's Notice of Privacy Practices in the new patient paperwork packet.

Patient/Guarantor Signature _____

Pharmacy Information

Name and Number/Cross Streets:

_____

Emergency Contact

Name: _____ **Phone Number:**_____

May we speak to your emergency contact if he/she contacts us on your behalf? **O** Yes **O** No

Please list the names and phone numbers of those individuals involved in your care or with whom you will allow us to share your health and treatment information – including family members and friends: ***(If none put N/A)***

Name:		**Phone:**	
Relationship:		Alternative Phone:	
Name:		**Phone:**	
Relationship		Alternative Phone:	
Name:		**Phone:**	
Relationship:		Alternative Phone:	

Michael Buckmire, MD | Rita Hadley, MD | Kevin Masur, MD | Jennifer Reitz, MD | Alvaro J. Testa Jr.,MD
Susan Cortesi, MD | Theodore Haley, MD | Matthew Marini, MD | Greg J. Rula, MD | Jessica Swanson NP
Lawrence Damore II, MD | Sumeet Kadakia, MD | Richard Oh, MD | Mark Runfola, MD
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Patient Request for Email Communications

Patient Name:_____ Date of Birth: _____

Phone Number: _____ Email Address:_____

Communications over the Internet and/or using the email system may not be encrypted and may not be secure. There is no assurance of confidentiality when communicated via email. To request that this provider communicate with you via email you must complete this form and return it to your health care provider's office.

Please be advised that:

(1) This request applies only to the healthcare provider or program that you indicate below. If you would like to request to communicate via email with another health care provider or program, you must complete a separate request for that office.
(2) Advanced Surgical Associates will not communicate health information that is specially protected under state and federal law (e.g. HIV/AIDS, substance abuse, and mental health information) via email.
(3) Your request will not be effective until you receive and respond to a test email message.

Please provide the answer to the question below for your test email:

The street number of my Residence: _____

I understand and agree to the following:

□ I certify the email address provided on this request is accurate, and that I accept full responsibility for messages sent to or from this address.
□ I have read and understood the Patient Email Communication and I am able to request a copy of this form.
□ I understand and acknowledge that communications over the Internet and/or using the email system may not be encrypted and may not be secure; that there is no assurance of confidentiality of information when communication this way.
□ I understand that all email communications in which I engage may be forwarded to other provider for purposes of providing treatment to me.
□ I agree to hold Advanced Surgical Associates and individuals associated with it harmless from any and all claims and liabilities arising from or related to this request to communicate via email.

_____ _____
Signature of patient or personal representative Date

_____ Advanced Surgical Associates
If personal representative, authority to act on Behalf of the patient

Name of Physician or Program