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 A copy of this authorization shall be valid until rescinded in writing or replaced by one at later date.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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www.advancedsurgery.com

Patient Email/Texting Informed Consent Form

1. Risk of using email/texting

   The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

   a. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
   b. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
   c. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
   d. Employers and on-line services have a right to inspect emails sent through their company systems.
   e. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
   f. Email and texts can be used as evidence in court.
   g. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. Conditions for the use of email and texts

   Advanced Surgical Associates, Ltd. cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Advanced Surgical Associates, Ltd. is not liable for improper disclosure of confidential information that is not caused by Advanced Surgical Associates, Ltd. intentional misconduct. Patients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:

   a. Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time. Email and text messages should not be time sensitive.
   b. Email and texts should be concise. The patient/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
   c. Email and text messages may be filed into your medical chart.
   d. Advanced Surgical Associates, Ltd. will not forward patient's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.
   e. Patients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
   f. Advanced Surgical Associates, Ltd. is not liable for breaches of confidentiality caused by the patient/parent/legal guardian or any third party.
   g. It is the patient's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment ifwarranted.

3. Patient Acknowledgement and Agreement

   I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of email and/or text messaging as a form of communication between Advanced Surgical Associates and me. I consent to the conditions and instructions outlined, as well as any other instructions that Advanced Surgical Associates may impose to communicate with me by email or text.

   Patient name: _____ Email: _____

   Patient Signature: _____ Date: _____

ADVANCED SURGICAL ASSOCIATES, LTD.

Advanced Surgical Associates (ASA) Prescription Refill Policy

Due to the alarming rate of narcotic pain medication abuse/dependence, it has become necessary for physician practices to closely manage patient use of prescription narcotic pain relievers, such as Vicodin, Vicoprofen, Hydrocodone, Tylenol #3 w/codeine, Percocet, Percodan, Lorcet, Lortab and Morphine products. ASA does not provide long-term pain management services. If long-term pain management is required, you will be referred to a pain management physician or your primary care physician.

If you are on chronic narcotics from a pain management physician, you will need to receive your post- operative pain medicine from that physician, unless pre-arranged with us prior to your surgery.

You may receive pain medication prescription as you prepare for a surgical procedure or during the normal post-operative period. Prescriptions are written for an appropriate period of time based on the your medical condition and type of surgery. Post–surgical patients will receive refills for no longer than a six (6) week period. Medications are to be taken according to directions. No early refills will be granted.

Routine refill requests will not be authorized after normal business hours Monday through Thursday, after 12 noon on Friday, during the weekend or on Holidays. Renewals requested during these times will be referred to the Emergency Room.

Arizona State Board of Pharmacy monitors each physician's prescribing record on a quarterly basis. Physicians will be required to query on patients receiving a prescription for a controlled substance.

Patient's Printed Name: _____

Patient's Signature:_____Date: _____