Advanced Surgery of Idaho

expert care from a compassionate team

Patient History

Date:

Name:	**Age:** **M or F**
Date of Birth:	**Marital Status: M S D W**
Primary Physician:	**Daytime phone #:**

Reason for visit (Describe all pertinent symptoms)**:**

Past Medical History (List all medical problems)**:**

Previous Surgeries:

Anesthesia complications? (You or a family member)

Current Medications (List dose, frequency and bring medications with you to appointment)**:**

Allergies to medications:

Occupation:	**Living Will?:**
Tobacco use (Type, amount, for how long, when quit)**:**	
Alcohol use (Type, amount, for how long, when quit)**:**	
Illicit drug use (Type, method, when)**:**	

Family History (List illnesses, current age or age at death and cause of death for each)**:**

Mother:

Father:

Sister:

Brother:

Other:

Any illnesses which are prevalent in your family:

SYSTEM REVIEW

General	Yes	No	Comment
Weight Gain/Loss	( )	( )	
Fevers	( )	( )	
Night Sweats	( )	( )	
Appetite	( )	( )	
Eyes			
Visual Change	( )	( )	
Eye Surgery	( )	( )	
Glaucoma	( )	( )	
ENT & Mouth			
Hearing problems	( )	( )	
Frequent nose bleeds	( )	( )	
sinus Problems	( )	( )	
Sores in mouth/throat	( )	( )	
Difficulty swallowing	( )	( )	
Lump sensation in throat	( )	( )	
Hoarseness	( )	( )	
Cardiovascular			
Heart attack	( )	( )	
High blood pressure	( )	( )	
Chest pain (angina)	( )	( )	
Heart surgery	( )	( )	
Congestive heart failure	( )	( )	
Shortness of breath	( )	( )	
Circulatory problems	( )	( )	
Leg cramps	( )	( )	
Foot pain/sores	( )	( )	
Surgery on arteries	( )	( )	
Phlebitis/blood clots	( )	( )	
Leg ulcers	( )	( )	
Respiratory			
Emphysema	( )	( )	
Chronic Cough	( )	( )	
Cough blood	( )	( )	
Lung surgery	( )	( )	
Pneumonia	( )	( )	
Asthma/Bronchitis	( )	( )	
Blood clots in lung	( )	( )	
Sleep apnea	( )	( )	
Gastrointestinal			
Abdominal pain	( )	( )	
Abdominal surgery	( )	( )	
Bloody vomiting	( )	( )	
History of ulcers	( )	( )	
Bowel changes	( )	( )	
Bloody/black stool	( )	( )	
Heartburn	( )	( )	
Jaundice	( )	( )	

Women Only

Last menstrual period	Yes	No	Comment
Birth control	**( )**	**( )**	
Menopause	**( )**	**( )**	
Pap smear/pelvic exam	**( )**	**( )**	
Pregnant now	**( )**	**( )**	

No. of Pregnancies _____ Births _____ Miscarriages _____

Musculoskeletal			
Hernia	( )	( )	
Arthritis	( )	( )	
Rheumatoid disease	( )	( )	
Muscle wasting/weakness	( )	( )	
Osteoporosis	( )	( )	
Orthopedic surgery	( )	( )	
Skin/Breast			
Skin cancer	( )	( )	
Non-healing sores	( )	( )	
Breast lump/biopsy	( )	( )	
Breast pain	( )	( )	
Nipple discharge	( )	( )	
Dimpling of breast skin	( )	( )	
Breast cancer	( )	( )	
Mammogram (when)	( )	( )	
Neurological			
Stroke	( )	( )	
Seizure/Epilepsy	( )	( )	
Severe head injury	( )	( )	
Numbness/tingling	( )	( )	
Psychiatric			
Depression	( )	( )	
Schizophrenia	( )	( )	
Other Psychiatric	( )	( )	
	( )	( )	
Endocrine			
Diabetes/metabolic disease	( )	( )	
Thyroid/Glandular disease	( )	( )	
High cholesterol	( )	( )	
Hematologic			
Bleeding disorder	( )	( )	
Take aspirin	( )	( )	
Blood transfusion	( )	( )	
Blood diseases	( )	( )	
Lumps	( )	( )	
Neck	( )	( )	
Armpits	( )	( )	
Groin	( )	( )	
Allergic/Immunologic			
Exposure to communicable diseases			
AIDS/HIV	( )	( )	
Hepatitis	( )	( )	
Tetanus vaccine (when)	( )	( )	
Prednisone/steroid use	( )	( )	
Genitourinary			
Kidney disease/Stones	( )	( )	
Painful/Bloody urination	( )	( )	
Difficult urination	( )	( )	

Dr. Initials/Date: _____

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Today's date: _____ Who may we thank for referring you: _____

Patient's name: _____
Last First Middle

Date of Birth: _____ Sex: ☐ Male ☐ Female Social Security #: _____

Residence Address: _____
Street City State Zip

Mailing Address (if different): _____
Street City State Zip

Home Phone: _____ Cell: _____ Email:_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Other
Student Status: ☐ FT ☐ PT ☐ Not a Student

Patient Employer: _____ ☐ Full Time ☐ Part Time
Occupation : _____ Work Phone: _____Is heavy lifting required? ☐ Yes ☐ No
Contact: _____
Name Title Phone Ext.

Spouse Name: _____
Date of Birth: _____ Social Security #: _____
Spouse Employer: _____ Work Phone: _____

Patient Primary Insurance Carrier: _____
Subscriber Name: _____ Policy #: _____
Group #: _____ Group Name: _____
Subscriber Date of Birth: _____Subscriber Social Security #:_____

Patient Secondary Insurance Carrier: _____
Subscriber Name: _____ Policy #: _____
Group #: _____ Group Name: _____
Subscriber Date of Birth: _____Subscriber Social Security #:_____

Please give us the name and phone number of a friend or family member **outside of the home** who can take a message for you if you are unavailable:

Name: _____ Phone #:_____
Relationship: _____

In case of an EMERGENY please contact:

Name: _____ Phone # : _____
Relationship: _____

Patient Signature: _____ Date: _____

Insurance Lifetime Assignment of Benefits

I request that payment of authorized insurance benefits be made on my behalf to Advanced Surgery of Idaho for any services furnished to me by its providers. This authorization is in effect until I choose to revoke it.

I understand and agree that any unpaid/balance is my financial responsibility. If I fail to pay for services for which I am responsible, after such default and upon referral to a billing service or collection agency by Advanced Surgery of Idaho, I will be responsible for all costs of collecting monies owed, including court costs, and collection agency fees.

My signature below reflects my acceptance of, and consent to, the information disclosed above.

** SIGNATURE: _____

DATE: _____

WITNESS: _____

CONSENT TO THE USE AND DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION (PHI) FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

- As part of my health care, THE SURGICAL GROUP, P. A., originates and maintains health records describing my health history, symptoms, examinations, diagnoses and treatment.

- The use and disclosure of my protected health information by THE SURGICAL GROUP, P.A. is necessary in order to provide me medical care, to obtain payment for my treatment and to carry out the practice's health care operations.

- I have the option to receive a copy of THE SURGICAL GROUP, P.A.'S Notice of Privacy Practices which provide a more complete description of the use and disclosure of my health information and that I have the right to review that Notice prior to signing this consent. I also understand that THE SURGICAL GROUP, P.A. will mail me a copy of any revised Notice prior to its implementation.

I have read and understand the foregoing notice:

Patients printed Name:_____ **Date:**_____

Patients signature:_____ **Date:**_____

Witness Signature:_____