PREMIER SURGICAL

Date ______________

PATIENT REGISTRATION

PATIENT INFORMATION **All Information is Confidential**

Social Security # ____________________ Sex _____ Date of Birth (month, day, year) ____________________

First Name ____________________ Middle ______________ Last ____________________

Home Address ____________________ City ____________________ State _______ Zip ___________

Home Phone ( ) ____________________ Work Phone ( ) ____________________ Cell Phone ( ) ____________________

Marital Status (circle one): Married Single Divorced Widowed Work Status: Employed Retired Student Other ___________

Employer ____________________ Address & Phone ____________________

Family Doctor/PCP ____________________ Cardiologist ____________________

Who referred you to our office? ____________________

PRIMARY INSURANCE INFORMATION

(Please provide your insurance card to the receptionist)

Circle One: Commercial Medicaid Medicare Worker's Compensation Other ____________________

Insurance Company ____________________

Insured/Card Holder's Name ____________________ Relationship ____________________

Policy # ________________ Group # ________________ Phone ( ) ____________________

SECONDARY INSURANCE INFORMATION

Circle One: Commercial Medicaid Medicare Worker's Compensation Other ____________________

Insurance Company ____________________

Insured/Card Holder's Name ____________________ Relationship ____________________

Policy # ________________ Group # ________________ Phone ( ) ____________________

WORKER'S COMPENSATION INFORMATION

Company Name ____________________ Company Phone ( ) ____________________

Supervisor's Name ____________________ Supervisor's Phone ( ) ____________________

EMERGENCY CONTACT

First Name ____________________ Middle ______________ Last ____________________

Relationship ____________________ Sex ___________

Home Phone ( ) ____________________ Work Phone ( ) ____________________

SPOUSE/GUARANTOR/RESPONSIBLE PARTY

First Name ____________________ Middle ______________ Last ____________________

Social Security # ____________________ Sex ______________ Date of Birth (month, day, year) ____________________

Relationship ____________________ Daytime Phone ( ) ____________________

Home Address ____________________ City ____________________ State _______ Zip ___________

Employer ____________________

Employer Address ____________________ City ____________________ State _______ Zip ___________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

Signature (Patient or Parent if Minor ____________________ Date ______________

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims..

Signature (Patient or Parent if Minor ____________________ Date ______________

PREMIER SURGICAL

Patient Name: ______________________________

FAMILY HISTORY

Cancer/Type: (colon, breast, etc.)	Mother ____________	Father ____________	Siblings ____________
Heart Disease/Type: (heart attack, high blood pressure, etc.)	Mother ____________	Father ____________	Siblings ____________

REVIEW OF SYSTEMS:

System	Item	Answer	Item	Answer
Constitutional:	Fever	YES ☐ NO ☐	Weight Loss	YES ☐ NO ☐
	Fatigue	YES ☐ NO ☐	Weight Gain	YES ☐ NO ☐
Eyes:	Glasses	YES ☐ NO ☐	Contacts	YES ☐ NO ☐
	Cataracts	YES ☐ NO ☐		
Ear/Nose/Throat:	Sinusitis	YES ☐ NO ☐	Nosebleeds	YES ☐ NO ☐
	Bleeding Gum	YES ☐ NO ☐	Swollen Neck Gland	YES ☐ NO ☐
	Dentures	YES ☐ NO ☐		
Cardiovascular:			Palpitations/Abnormal Rhythm	YES ☐ NO ☐
			Chest Pain/Pressure	YES ☐ NO ☐
			Shortness of Breath with Walking or Lying Flat	YES ☐ NO ☐
			Swelling of Feet or Ankles	YES ☐ NO ☐
			Abnormal Heart Valve	YES ☐ NO ☐
Respiratory:	Wheezing	YES ☐ NO ☐	Chronic or Frequent Cough	YES ☐ NO ☐
			Coughing up blood	YES ☐ NO ☐
Gastrointestinal:	Loss of Appetite	YES ☐ NO ☐	Difficulty Swallowing	YES ☐ NO ☐
	Nausea	YES ☐ NO ☐	Vomiting	YES ☐ NO ☐
	Diarrhea	YES ☐ NO ☐	Constipation	YES ☐ NO ☐
	Jaundice	YES ☐ NO ☐	Blood in bowel movements	YES ☐ NO ☐
Genitourinary:	Frequent Urination	YES ☐ NO ☐	Blood in Urine	YES ☐ NO ☐
	Kidney Stones	YES ☐ NO ☐	Burning/painful urination	YES ☐ NO ☐
	Females: Age at menarche ______		Last menstrual period ____________	
Musculoskeletal:	Back Pain	YES ☐ NO ☐	Joint Pain, Stiffness or Swelling	YES ☐ NO ☐
Neurologic:	Headache	YES ☐ NO ☐	Dizziness	YES ☐ NO ☐
	Alzheimers/Dementia	YES ☐ NO ☐	Fainting Tremor Paralysis	YES ☐ NO ☐
Heme/Lymphatic:	Anemia	YES ☐ NO ☐	Bleeding or bruise easily	YES ☐ NO ☐
	Previous transfusion	YES ☐ NO ☐	Enlarged glands	YES ☐ NO ☐
	Reaction to anesthesia	YES ☐ NO ☐	If yes, please explain: ____________	
Endocrine:	Heat or cold intolerance	YES ☐ NO ☐	Underactive Thyroid Gland	YES ☐ NO ☐
			Overactive Thyroid Gland	YES ☐ NO ☐
Skin:	Rash	YES ☐ NO ☐	Mole or lesion that has changed color or size	YES ☐ NO ☐

Psychiatric: Anxiety YES ☐ NO ☐ Depression YES ☐ NO ☐ Panic Attacks YES ☐ NO ☐

Other: ____

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HEALTH HISTORY

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Date: ____________________

Name: ____________________ Birthdate: ____________________

Reason for this visit: ____________________

Allergies: ____________________

Current Medications (include nonprescription): | Dose:

ILLNESSES:

Illness			Illness		
AIDS?	YES ☐	NO ☐	Heart Attack?	YES ☐	NO ☐
Alcoholism?	YES ☐	NO ☐	Hepatitis?	YES ☐	NO ☐
Angina?	YES ☐	NO ☐	High Cholesterol?	YES ☐	NO ☐
Arthritis?	YES ☐	NO ☐	Hypertension?	YES ☐	NO ☐
Asthma?	YES ☐	NO ☐	Obesity?	YES ☐	NO ☐
COPD?	YES ☐	NO ☐	Pacemaker/Defibrillator?	YES ☐	NO ☐
Congestive Heart Failure?	YES ☐	NO ☐	Rheumatic Fever?	YES ☐	NO ☐
Diabetes?	YES ☐	NO ☐	Sleep Apnea?	YES ☐	NO ☐
Glaucoma?	YES ☐	NO ☐	Stroke?	YES ☐	NO ☐
Gout?	YES ☐	NO ☐	Other: ____________________		

SURGERIES: | **DATE:**

Tobacco: Never | Previously, but quit | Current packs/day _____ | Pipe, cigar, chew

Alcohol: Never | Occasionally | Frequently