**SURGICAL CRITICAL CARE ASSOCIATES, LLP**

**PATIENT HISTORY**

**NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AGE**: \_\_\_\_\_\_\_\_\_\_ **DATE OF BIRTH**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **HEIGHT**: \_\_\_\_\_\_\_\_\_\_\_ **WEIGHT**:\_\_\_\_\_\_\_\_

**REASON FOR VISIT**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OCCUPATION**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **FULL DUTY** \_\_\_\_\_ **LIGHT DUTY** \_\_\_\_\_ **NOT WORKING** \_\_\_\_\_\_

**FAMILY HISTORY**: \_\_\_Muscle or Bone Disease (Inherited) what kind?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Problems with Anesthesia or Anesthetic: What Happened?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_bleeding problems \_\_\_Scoliosis \_\_\_Arthritis at young age \_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATION ALLERGIES**: Allergic to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ what happens?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergic to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ what happens?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT MEDICATIONS**:(List all current medication including over-the-counter such as aspirin and herbal supplements)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DO YOU HAVE ILLNESS**? (Check all that apply)

\_\_High/\_\_Low Blood Pressure \_\_Blood Clots \_\_Seizures \_\_Lung Problems/Asthma \_\_Swelling in legs & feet

\_\_Rheumatoid Arthritis \_\_Varicose Veins \_\_HIV \_\_Bleeding Problems \_\_Thyroid \_\_Hyper \_\_Hypo

\_\_Sleep Apnea \_\_C-Pap \_\_Kidney Problems \_\_Gout \_\_Hepatitis \_\_Ulcer/Stomach Problems

HEART: \_\_Heart disease \_\_Heart Attach \_\_Murmur \_\_Mitral Valve Prolapse \_\_Congestive heart failure

DIABETIC: \_\_Insulin \_\_Oral Meds \_\_Diet CANCER: \_\_Benign \_\_Malignant

**PRIOR SURGERIES**: (Include all surgeries and dates of surgeries)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you drink alcohol**? Y N Quantity?\_\_\_\_\_ Do you smoke Y N Quantity?\_\_\_\_\_\_ Do you use drugs? Y N

**FEMALES ONLY**: Are you pregnant? Y N Have you had a baby within the last month? Y N Date:\_\_\_\_\_\_\_\_

Are you on hormone therapy? Y N Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose\_\_\_\_\_\_\_\_\_\_

Are you currently taking birth control pills? Y N How long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Hysterectomy \_\_Full \_\_Partial \_\_Tubal Ligation Date of last menstrual period?\_\_\_\_\_\_\_\_\_\_\_

**Surgical Critical Care Associates, LLP**

**PATIENT REGISTRATION FORM**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_ Sex: F M

Last First MI

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_

Email(SCCA use only)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number\_\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ext:\_\_\_\_\_

**Marital Status**: \_\_\_Single \_\_\_Married \_\_\_Divored \_\_\_Separated \_\_\_Widowed

Preferred Pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***WHO MAY WE CONTACT IN CASE OF AN EMERGENCY?***

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF PATIENT IS LESS THAN 21 YEARS OF AGE PLEASE LIST**:

Mother’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance** **Information**: (We need to make a copy of your insurance cards for our billing records)

1.Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured employed by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured employed by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical Critical Care Associates, LLP**

MEDICAL INFORMATION RELEASE: HIPPA (Initial #1 and complete #2)

1.\_\_\_\_\_\_\_(Initial) I acknowledge I was provided with the “Notice of Privacy Practices” of SCCA.

Complete #2 for anyone that you authorize SCCA to speak with regarding your private health information.

Without this authorization SCCA is unable to discuss any information with anyone (including spouse) outside of the medical field.

2. I hereby authorize the use and disclosure to individually identifiable health information relating to me as indicated below to be released to the following individuals: (including spouse, parent, child, ect. If applicable)

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check boxes of information authorized to release to the above noted person(s):

\_\_Medical records/X-rays \_\_Billing records \_\_Testing/lab results \_\_Appointments issues \_\_All the above

ALL AUTHORIZATION EXPIRES ONE YEAR AFTER SIGNED DAY. You may revoke any authorization by providing written notice to our administrations attention. I understand that if the person receiving this information is not health plan or health care provider covered by the federal privacy regulations; the authorized information may be re-disclosed by the information release and that my refusal to sign in no way affects my treatment; payment; enrolled in a health plan; or eligibility for benefits.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*FINANCIAL POLICY AND PATIENT FINANCIAL RESPONSIBILITY*

***PATIENT RESPONSBILITY***: You as a patient are ultimately responsible for all fees. All payments, co-payments, co-insurances, and deductibles are due at the time of service. All patients under 18 years of age must be accompanied by an adult who is responsible for any necessary payments and deductibles at the time of service.

***PATIENTS WITH HEALTH COVERAGE***: We do accept insurance assignment and we will file your insurance claims for you if you have provided us with a copy of your insurance card at the time of service. You are responsible for all co-payments or balances as required by your specific insurance plan. You need to bring your insurance card to each visit. Your appointment will be rescheduled if your insurance card is not available. If the initial given insurance coverage change at any time during your care, immediately provide a copy of the new insurance card to SCCA patient representative or our billing company. If your insurance plan REQUIRES A REFERRAL, THIS MUST BE OBTAINED FROM YOUR PRIMARY CARE PHYSICIAN PRIOR TO YOUR COMING INTO THE OFFICE. It is your responsibility to obtain the referral. If this referral is not received or obtained when you arrive for your visit your insurance company will not honor the visit so your appointment will be rescheduled.

***PATIENTS WITHOUT INSURANCE COVERAGE***: If you do not have healthcare coverage, you are required to make a $200.00 payment prior to seeing the physician. Immediately following your appointment the cashier will total the chart for the cost of the visit. If the charges exceed $200.00 you will be asked to pay the remaining balance. If the total is under $200.00 you will be refunded the difference.

SCCA accepts the following methods of payments: Cash, Check, Money Order, debit, Mastercard, or Visa.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical Critical Care Associates, LLP**

Please read and sign where indicated:

Consent of Treatment:

I know I have a condition that requires medical or diagnostic treatment. I hereby do voluntarily consent to such care and/or procedure and to such medical or other services under the general instruction of Dr. Parkus, Dr. Kavouspour, and/or Dr. Wooten, their assistants, or their designee as is necessary in their judgement. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as the result of treatment.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Assignment of the Benefits and Release:

I certify that I, and/or my dependent(s), have insurance coverage with the above mentioned carrier(s), and assign directly to Surgical Critical Care Associates, LLP all insurance benefits for services rendered. I authorize the use of my signature on all insurance claim submissions. I understand that I am financially responsible for all charges not paid by my insurance carrier.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_