Patient Information Form

Cape Girardeau Surgical Clinic, Inc.

Thank you for choosing Cape Girardeau Surgical Clinic. Please fill out this form completely to ensure you receive the best healthcare service we can provide.

PERSONAL INFORMATION

Patient Name: Maiden Name (if applicable):	Social Security Number: What year was your last appointment here?
Date of Birth: Current Age: Gender: M F Marital Status: M S D W	Address:
Referring Physician:	Primary Care Physician:
Home Phone:	Employer:
Cell Phone:	Work Phone:
Email Address:	Occupation:
Name of Spouse (if married) or Parent/Legal Guardian (if child): Spouse or Parent contact number:	
Emergency Contact Name:	Phone:

GUARANTOR INFORMATION

Fill out this section only if you are covered under the insurance policy of a spouse, partner, parent or legal guardian. Otherwise, you may skip this section. If you are covered under the insurance policy of someone else, please tell us about this person:

Name: Date of Birth:

Social Security Number:

Your relationship to this person (circle one): Parent Legal Guardian Spouse Partner

Address:

Home Phone:	Cell Phone:
Employer:	Occupation:

DEMOGRAPHIC INFORMATION

The American Recovery and Reinvestment Act of 2009 requires us to ask for the information below. This data is for national collection purposes only and does not influence the care you receive at Cape Girardeau Surgical Clinic.

RACE: Biological Descent
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Other _____
- ☐ Declined

ETHNICITY: Cultural Group
- ☐ White
- ☐ Black or African American
- ☐ Hispanic
- ☐ Asian
- ☐ Chinese
- ☐ Other_____
- ☐ Declined

PREFERRED LANGUAGE:
- ☐ English
- ☐ Spanish
- ☐ Other_____
- ☐ Declined

RELEASE OF INFORMATION

With whom may we discuss information about your medical care?

Name: Relationship:

Name: Relationship:

Name: Relationship:

Patient Signature of Authorization: _____ Date: _____

Cape Girardeau Surgical Clinic, Inc.

1. Authorization for Release of Information

I authorize Cape Girardeau Surgical Clinic, Inc. to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare or any other third-party payers. I authorize Cape Girardeau Surgical Clinic, Inc. to release all medical information to my referring physician and my primary (family) physician. I authorize Cape Girardeau Surgical Clinic, Inc. to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Cape Girardeau Surgical Clinic, Inc.

I agree that these provisions will remain in effect until I provide written revocation to Cape Girardeau Surgical Clinic, Inc.

Signature of Patient/Legal Guardian: _____ Date: _____

2. Assignment of Benefits

I hereby assign to Cape Girardeau Surgical Clinic, Inc. any insurance or other third-party benefits available for health care services provided to me. I understand that Cape Girardeau Surgical Clinic, Inc. has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Cape Girardeau Surgical Clinic, Inc., I agree to forward to Cape Girardeau Surgical Clinic, Inc. all health insurance and other third-party payments that I receive for surgical services rendered to me immediately upon receipt.

Signature of Patient/Legal Guardian: _____ Date:_____

3. Insurance Coverage Waiver

I understand that my eligibility for coverage by (name of insurance company) _____

_____cannot be confirmed at this time. I wish to receive medical service from a Cape Girardeau Surgical Clinic, Inc. physician. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

Signature of Patient/Legal Guardian: _____ Date: _____

PLEASE BE ADVISED: Your account will be turned over to a collection agency if you do not pay on your personal balance every 30-days.

QUESTIONS AND COMPLAINTS

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Cape Girardeau Surgical Clinic, Inc.
Breast Care & Diagnostic Center
Sarah J. Holt
Administrator
60 Doctors' Park
Cape Girardeau, MO 63703
Telephone (573) 334-3074 or 334-6464

If you think that we may have violated your privacy rights, contact the person named above. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

Name_____

Signature_____

Date_____

Patient History

Cape Girardeau Surgical Clinic, Inc.

Name: _____Date:_____

Date of Birth:_____Age: _____ Gender: M F

Referring Physician: _____ Family Physician: _____

Do you see any specialists? □ Cardiologist □ Gastroenterologist □ None □ Other_____

CHIEF COMPLAINT (Reason you are here today, including any symptoms): _____

_____

How long have you had this problem? _____

Have you had any tests performed for this problem? If yes, please list: _____

_____

_____

Do you have a hospital preference? □ Saint Francis □ Southeast □ Either

Medical History

Illnesses

Have you ever had or do you have (Check any that apply):

□ High Blood Pressure
□ Heart Disease
□ Diabetes
□ Kidney Disease
□ Stroke
□ Aneurysm
□ Blood Clots
□ Asthma
□ Cancer
□ TB
□ Hepatitis
□ HIV or AIDS
□ Emphysema/COPD
□ None of the above
□ Please list other:_____

Surgeries *(Please check ALL surgeries you have had in the past)*

□ Appendectomy
□ Mastectomy
□ Gall Bladder
□ Stomach
□ Colon
□ Rectal
□ Lung
□ Thyroid
□ Hysterectomy
□ Ovaries Removed
□ Prostate
□ Hernia Repair
□ Organ Transplant
□ Heart surgery/procedure
□ None of the above
□ Please list any other surgeries:
_____
_____
_____
_____
_____
_____

Have you ever had a colonoscopy? Yes No If "yes," when? _____ What doctor? _____

Injuries *(Please check any serious injuries you have had in the past)*

□ Broken Bones - Location of fracture(s):_____
□ Lung □ Abdomen □ Head □ None
□ Please list other: _____

Family History

(Mother, Father, Sisters, Brothers, Grandparents, Aunts, Uncles)

Disease/Condition	What Kind?	Who?
□ Cancer	_____	_____
□ Diabetes	_____	_____
□ Heart Disease	_____	_____
□ Vascular Disease (Aneurysm, Strokes)	_____	_____
□ Other	_____	_____

□ NO FAMILY HISTORY OF THE ABOVE

Circle the appropriate answer:

Father: Alive / Deceased Mother: Alive / Deceased

Tobacco Use

Do you smoke or have you ever smoked? Y N How much per day? _____

How long have you smoked? _____

Have you ever used illegal drugs? Y N

Do you drink alcohol? Y N If yes, how often? □ Daily □ Weekly □ Monthly

Review of Systems

Cape Girardeau Surgical Clinic, Inc.

Name: _____ Date:_____

Check the boxes below if you are **CURRENTLY** experiencing any of these symptoms or conditions.

CONSTITUTIONAL SYMPTOMS

- ☐ High blood pressure
- ☐ Fever and/or shaking chills
- ☐ Recent weight loss
- ☐ Recent weight gain

EYES

- ☐ Blurring and double vision
- ☐ Vision loss
- ☐ Halos around lights

EAR, NOSE AND THROAT

- ☐ Ringing or buzzing in your ears
- ☐ Difficulty hearing
- ☐ A lump or fullness in your neck
- ☐ Get hoarse frequently

CARDIOVASCULAR

- ☐ Heart trouble
- ☐ Serious chest pain
- ☐ Stop when climbing a flight of stairs
- ☐ Previous stroke
- ☐ Irregular heartbeat

How far can you walk without leg pain? ☐ 1 Block ☐ 1 Mile ☐ Other_____

RESPIRATORY

- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Get winded easily
- ☐ TB
- ☐ Asthma

GASTROINTESTINAL

- ☐ Stomach ulcers
- ☐ Constipation/Hemorrhoid problems
- ☐ Frequent diarrhea
- ☐ Difficulty swallowing
- ☐ Stomach pain
- ☐ Blood in your stool
- ☐ Vomiting blood
- ☐ Heartburn/Indigestion
- ☐ Black bowel movements
- ☐ Burping up hot liquid

GENITOURINARY

- ☐ Pain or burning when urinating
- ☐ Get up frequently at night to urinate
- ☐ Passing blood in your urine
- ☐ Kidney stones

MUSCULOSKELETAL

- ☐ Swelling in ankles and/or legs
- ☐ Frequent joint pain
- ☐ Muscle weakness/spasms
- ☐ Cramps in your legs when walking

SKIN

- ☐ Any skin problems
- ☐ Any recent skin rashes

NEUROLOGICAL

□ Numbness or weakness of an arm or leg
□ Loss of sight in one eye for a short time
□ Dizzy or fainting spells
□ History of seizures or convulsions

PSYCHIATRIC

□ Have you ever been treated for, or are you susceptible to depression? □ Yes □ No
□ Have you ever been treated for, or are you susceptible to anxiety order? □ Yes □ No

ENDOCRINE

□ Frequent urination
□ Excessive thirst
□ A wound that will not heal
□ History of diabetes
□ Rapid pulse or palpitations
□ Extreme nervousness or sweating
□ Recent unexplained weight loss

HEMATOLOGIC/LYMPHATIC

□ Bruise easily
□ Bleed easily
□ Night sweats
□ Swollen lymph nodes
□ Chills or fever
□ Loss of appetite and/or persistent fatigue

ALLERGIC/IMMUNOLOGIC

□ Urticaria (hives)
□ Hay fever
□ Persistent infection
□ HIV exposure

THE REMAINING ITEMS BELOW ARE FOR WOMEN ONLY.

BREASTS

□ New masses
□ Breast skin lesions
□ Abnormal breast swelling
□ Nipple discharge
□ Breast pain
□ Breast skin dimpling
□ Nipple changes

At what age was your first menstrual cycle? _____ When was your last menstrual cycle?_____

When was your last mammogram?_____ When was your last pap smear?_____

How many pregnancies have you had? _____ Did you breast feed? Yes No

How old were you when your first child was born? _____ Are you pregnant now? Yes No

How many living children do you have? _____ Have you gone through menopause? Yes No

Patient Signature: _____ Date: _____

Patient Medication List

Cape Girardeau Surgical Clinic, Inc.

Name:_____ Date:_____

Do you have any medication allergies? No Yes

If you circled "Yes," please list your medication allergies and the reaction you experience:_____

_____

_____

PLEASE LIST ALL CURRENT PRESCRIPTIONS BELOW			
NAME OF MEDICINE	**DOSE (MILLIGRAMS)**	**HOW MANY TIMES PER DAY?**	**Reviewed & Updated**
PLEASE LIST ANY OVER THE COUNTER MEDICINES (VITAMINS AND HERBAL REMEDIES)			

Are you taking Aspirin or Blood Thinners? □ Aspirin □ Coumadin □ Plavix □ None

Are you taking steroids? □ Prednisone □ None □ Other: _____

Are your immunizations up to date? Y N What is the date of your last tetanus shot? _____

Which local pharmacy do you use? _____

Patient Signature:_____Date:_____

Reviewed by Physician:_____Date:_____

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