PATIENT HISTORY SHEET

Patient Name:_____ Date of Birth:_____ Today's Date:_____
Reason for visit:_____ How long had issue:_____
How Severe: ___Mild___Moderate___Severe Location of issue:_____
Primary Care Physician: First/Last_____ Referring Physician:_____

PAST MEDICAL HISTORY

_____ I deny any past illness

___ Anemia	___ COPD	___ Gerd	___ HIV/AIDS	___ Sleep Apnea
___ Arthritis	___ CPAP	___ Head/Neck Injury	___ Hypertension	___ STD
___ Asthma	___ Deep Vein Thrombosis	___ Headaches	___ Kidney Disease	___ Stomach Ulcer
___ Bleeding Problems	___ Depression	___ Heart Attack	___ Kidney Stones	___ Stress Test
___ Blood Transfusion	___ Diabetes Type 1	___ Heart Murmur	___ Liver Disease	___ Stroke
___ Chest Pain	___ Diabetes Type 2	___ Hepatitis	___ Nervous Disorder	___ Thyroid Disease
___ Congestive Heart Failure	___ Echocardiogram	___ Hernia	___ Pulmonary Embolism	___ Cancer/Type
___ Convulsions	___ Emphysema	___ Hiatal Hernia	___ Seizures	_____

PAST SURGICAL HISTORY

_____ I deny any past surgeries

Indicate the date surgery was performed:

Abdominal Surgery_____	Adenoidectomy_____	Gallbladder_____	Other_____
Appendix_____	Hysterectomy_____	Tonsillectomy_____	Other_____
Hernia_____		Back Surgery_____	

Medication Information

List all MEDICATIONS you are currently taking including "dosage" & "directions" _____ I deny taking any medications

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergy Information

List all ALLERGIES (medications,etc) and your "physical reactions" _____ I deny having any allergies

_____ _____ _____
_____ _____ _____
_____ _____ _____

Latex Allergy ___Yes ___No Reaction_____

Martial Status: Single Married Separated Divorced Widowed Significant Other

Alcohol Use: Never Rarely Moderate Daily, amount per week _____

Tobacco Use: Never Former Smoker Current Age Started_____, Stopped_____# of pks per day____

Smokeless Tobacco: Never Former Smoker Current Age Started_____, Stopped_____

Non-prescription Drug Use: Never Type/Frequency_____

Do you wear dentures: Yes No

Revised 2/2/15

Continued on back

Patient's Personal History

CHECK only the symptoms that YOU have had within the past year.

GENERAL
- Fever ____
- Chills ____
- Fatigue ____
- Weight change ____
- Night sweats ____

EYES
- Change in vision ____
- Blurred or Double Vision ____

ENT
- Sore throat or voice change ____
- Nasal congestion ____
- Sinus problems ____
- Headaches ____
- Hearing loss ____
- Ringing in ears ____
- Earache or drainage ____
- Nose bleeds ____
- Mouth sores ____
- Bleeding gums ____
- Difficulty swallowing ____
- Swollen neck glands ____

BREAST
- Lumps ____
- Tenderness/Pain ____
- Discharge ____

CARDIOVASCULAR
- Chest pain ____
- Irregular heartbeats ____
- Shortness of breath on exertion ____
- Swelling of feet, ankles or hands ____

RESPIRATORY
- Frequent coughing ____
- Shortness of breath ____
- Sleep apnea ____
- Wheezing or Asthma ____
- Spitting up blood ____

GASTROINTESTINAL
- Heartburn / Indigestion ____
- Loss of appetite ____
- Nausea / Vomiting ____
- Irritable Bowel Syndrome ____
- Change in bowel movements ____
- Diarrhea ____
- Constipation ____
- Abdominal Pain / bloating ____
- Blood in stool ____
- Painful bowel movements ____
- Rectal bleeding ____
- Hemorrhoids ____

GENITOURINARY
- Urgency / frequency ____
- Difficulty, painful urination ____
- Blood in urine ____
- Incontinence or dribbling ____
- Urinary tract infections ____
- Urinary retention ____
- Change of force with urinating ____
- Kidney stones ____

SKIN
- Rash / itching ____
- Change in moles or lesions ____
- Varicose Veins ____

NEUROLOGICAL
- Tingling or numbness ____
- Coordination difficulty ____
- Stroke ____
- Memory difficulties ____
- Seizures ____
- Tremors ____
- Light headed or dizzy ____
- Paralysis ____

MUSCULOSKELETAL
- Back pain ____
- Joint pain, swelling or stiffness ____
- Muscle pain or weakness ____

ENDOCRINE
- Excessive Thirst ____
- Glandular or hormone problems ____
- Thyroid disease ____
- Heat or cold intolerance ____
- Dry skin / allergic dermatitis ____

PSYCHIATRIC
- Anxiety / Nervousness ____
- Depression ____
- Memory loss or confusion ____
- Sleep problems ____

HEMATOLOGICAL / LYMPHATIC
- Bruise or Bleed easily ____
- Enlarged / Tender lymph nodes ____
- Slow to heal after cuts ____
- Anemia ____
- Phlebitis ____
- Past blood transfusion ____
- Taking any Blood Thinners ____

MALE
- Testicle pain or mass ____

FEMALE
- Painful periods ____
- Irregular periods ____
- Vaginal discharge ____
- # pregnancies _____,
- # miscarriage _____
- Date of last pap smear _____.
- Result pap smear: _____

I have confirmed the above information to be correct.

Patient's Signature _____, Date: _____

Completed by: _____, (if other than the patient). Date: _____

Your relationship to the patient: _____

I have reviewed the patient's history information.

Physician's Signature: _____, Date: _____

Patient Name:

Family History Form

Indicate which relative has the following diseases:

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Aunt(s)	Uncle(s)
Anesthesia Issues										
Bleeding or Clotting Issues										
Cancer - Breast										
Cancer - Colon										
Cancer - Gallbladder										
Cancer - Other Type										
Cancer - Ovarian										
Cancer - Prostate										
Cancer - Stomach										
Diabetes										
Heart Disease										
High Blood Pressure - Hypertension										
Kidney Disease										
Liver Disease										
Nervous Disorder										
Stroke										
Urinary										

PATIENT INFORMATION

Last Name: _____, First Name: _____, Middle: _____, DOB: _____

Gender: □ Male □ Female SS#: _____ Race: □ White □ African American □ Other

Marital Status: □ Divorced □ Married □ Single □ Widowed Ethnicity: □ Hispanic □ Non-Hispanic □ Other

Street Address: _____

City State Zip

Phone: Home: _____, Cell: _____, E-mail Address Required: _____

Pharmacy: _____City:_____State:_____Phone_____

Primary Care Physician: First/Last_____ Referring Physician: _____

Preferred Communications: □ Phone □ Text □ Email □ Portal May we leave a message: □ Yes □ No

Employer: _____, Occupation: _____, Work #:_____

Is the patient under 18 years of age? ☐Yes □No If yes, please fill in below:
Ins. Cardholder Name: _____ DOB: _____ SS#: _____

Worker's Compensation?☐Yes☐No
Date of Accident: _____Adjuster:_____

I authorize Bristol Surgical Associates to communicate my healthcare, appointment and/or billing information to the following people:

Name: _____ *D.O.B.:* _____ *Relationship to patient:* _____ *Phone #:* _____

Name: _____ *D.O.B.:* _____ *Relationship to patient:* _____ *Phone #:* _____

Name: _____ *D.O.B.:* _____ *Relationship to patient:* _____ *Phone #:* _____

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history including, symptoms, examination, test results, diagnoses, treatment, and any plans for further care or treatment. I understand that this information serves as a basis for planning my care and treatment, a means of communication among the many health professionals who contribute to my care, a source of information for applying my diagnosis and surgical information to my bill, a means by which a third party payer can verify that services billed were actually provided, and a tool for routine healthcare operation such as assessing quality and reviewing the competence of healthcare professionals.

I CONSENT TO TREATMENT NECESSARY FOR THE CARE OF THE UNDERSIGNED PATIENT.

We do not assume responsibility for determining if your insurance carrier requires a second opinion. We do not assume responsibility for motor vehicle / liability claims. We are not participating providers will all insurance carriers, it is the responsibility of the patient to verify insurance participation with Bristol Surgical Associates. Payment is due upon check in; any balance 90 days or older will be subject to a 12% APR. Outstanding accounts will be turned over to collection and the undersigned will be responsible for all collection agency fees, court costs and attorney fee.

INFORMATION RELEASE/BENEFIT ASSIGNMENT

I hereby assign and authorize payment directly to the attending physicians / surgeon for services rendered. I further authorize the release of any medical information or medical records for purposes of benefit payment. I hereby authorize Bristol Surgical Associates to obtain my credit report for the sole purpose of obtaining payment. I authorize a representative including but not limited to collection or billing companies of Bristol Surgical Associates to contact me by any and all contact information, including wireless or mobile telephone numbers listed within my medical record. I hereby give my consent to be contacted by any means including but not limited to a dialing service or pre-recorded message listed within my EHR.

The undersigned individual obligates himself to the payment of this account incurred by the patient in accordance with regular rates and terms of this office. The undersigned certifies that he has read, accepts and understands these terms.

No Show Policy for Doctor Appointment

I understand if an appointment is not cancelled at least 24 hours in advance I will be charged $25; this will not be covered by the insurance company and will be patient responsibility.

Patient's Signature: _____ *Today's Date:* _____

Responsible Party's Signature: _____ *Today's Date:* _____
(Required if patient is under the age of 18)

Bristol Surgical Associates, P.C.

Patient Financial Agreement

The following information is provided to all of our patients, new and established, to inform patients of our office financial policies and of patient financial responsibility requirements.
Please ask one of our team members if you have any questions regarding these policies.

- We will be happy to bill your insurance as a courtesy; however, all charges, regardless of insurance coverage are the patient's responsibility. We do expect payment for your portion at the time of service. (co-pays, co-insurance, deductibles). We ask that if your insurance has not paid within 45 days that you follow up with them. Our office contracts with most insurance carriers.

- If you are seen for both a wellness/annual exam and an illness of separate problem is also addressed, proper coding will be used which may result in a charge for both services. Additionally, some medically indicated lab work may not be covered by all wellness policies. Your individual contract with your insurance carrier will determine how your insurance will pay. We make every effort to bill each visit with the proper diagnosis and procedure codes according to national coding guidelines. Please understand that we cannot make exceptions to our coding practices due to federal and state legal compliance concerns, and we are unable to bill for services other than those documented in your medical record.

- Injections and some medical supplies must be paid for in advance at the time of service. Specialized products or services must be preauthorized with insurance prior to service; otherwise, these services will need to be paid in full by the patient at the time of service.

- For surgical care, we will pre-certify your insurance and obtain the estimated patient responsibility for the procedure. This amount is due prior to the scheduled date of surgery. If the procedure results in additional charges, these fees will be billed to you. **We would ask that you pay the balance within 30 days following your surgery. Acceptable paymentincludes cash, check, VISA, MasterCard, Discover, American Express or CareCredit.**

- We routinely send our laboratory testing to third-party laboratory companies. The aforementioned providers may or may not participate with your health plan. You may request that we refer your testing to another location. This request will need to be done with each visit.

- It is necessary to strictly enforce the policy of financial obligation. All co-pays, patient self-payment, and estimated care patient financial responsibility may be paid by cash, check, VISA, MasterCard, Discover, American Express or Care Credit. Only additional fees will be invoiced by the office to the patient. These are due within 30 days of receipt of invoice.

- There may be a charge for a no show of less than 24 hour cancellation (business hours) of $25.00 for office visits and $100 for surgical procedures. This fee is the responsibility of the patient and cannot be filed with insurance companies. Cancellation messages must be made with the office during regular business hours and cannot be made with the after-hours answering service in an effort to avoid this charge.

- Paperwork (for example Family Medical Leave Act (FMLA) & Short Term Disability applications) will be completed within a week of presentation. The charge for each form is $10, payable in full at the time the form is left for completion.

- Finance charges will accrue on balances over 90 days at a rate of 1.0% per month (12% per annum (APR)).

I have read and understand the above information and agree to comply with these financial policies.

Signature: _____

Print Name: _____ Date: _____