PATIENT NAME:_____ **DOB:**_____

HAVE YOU HAD ANY OF THE FOLLOWING:

COLONOSCOPY: YES_____ NO_____

IF YES, WHEN AND WHERE? _____

EGD: YES_____ NO_____

IF YES, WHEN AND WHERE? _____

MAMMOGRAM: YES_____ NO _____

IF YES, WHEN AND WHERE? _____

HERNIA REPAIR: YES_____ NO_____

IF YES, WHEN AND WHERE? _____

Patient Information Sheet

Social Security Number:_____ Referring Physician:_____ Sex:_____

Last Name:_____ First Name:_____ Middle:_____

Address:_____

City:_____ State:_____ Zip:_____

Date Of Birth:_____ Home Phone:_____ Cell:_____ Cell Carrier:_____

Email Address: _____**Preferred method of appointment reminders: TEXT/ EMAIL (circle one)**

Employer: _____ Employer Phone:_____

Employer Address: _____

Marital Status: S M W D (circle one) Spouse Name: _____ Employer: _____

Emergency Contact Name: _____ Emergency Contact Phone Number: _____

Person responsible for charges (other than the patient):

Last Name:_____First:_____Middle:_____

Relationship to patient:_____ DOB:_____ SSN:_____

Address:_____ City:_____ State:_____

Employer:_____ Phone:_____

Employer Address:_____ City:_____ State:_____

Insurance Information

Primary_____Policy#:_____Group#:_____

Subscriber's Name:_____ DOB:_____ Copay:_____

Secondary_____

Subscriber's Name:_____ DOB:_____ Copay:_____

Other:_____

Subscriber's Name:_____ DOB:_____ Copay:_____

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered, unless other arrangements have been made in advance with our office manager. **COPAYS ARE DUE AT THE TIME OF SERVICE.** I authorize the release of any medical information to process a claim on my behalf. I also authorize payment of medical benefits to Advanced Surgical Care, P.C.

Patient Signature or authorized representative:_____ Date:_____

ADVANCED SURGICAL CARE, P. C.
Policy 7
CONSENT FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT, AND HEALTH CARE OPERATIONS

By signing below, you hereby consent for **Advanced Surgical Care, P.C.** to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose of treatment, payment, and health care operations. You may refuse to sign this consent form.

You should read the Notice of Privacy Practices for PHI attached to this form, before signing this consent. The terms of the notice may change from time to time, and you may always get a revised copy by asking the privacy officer for **Advanced Surgical Care, P.C.**

You have the right to request that **Advanced Surgical Care, P.C.** restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. **Advance Surgical Care, P. C.** is not required to agree to requested restrictions; however, if **Advanced Surgical Care, P.C.** agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing this below, you recognize that the protected health information used or disclosed pursuant to this consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

The following people have the right to see, review, listen to results or treatment plans, call on my behalf and speak with the office of Advanced Surgical Care, P. C. about my health care.

1. **Name**_____**Phone#**_____**Relationship**_____
2. **Name**_____**Phone#**_____**Relationship**_____
3. **Name**_____**Phone#**_____**Relationship**_____

***Patient's Signature or Personal Representative:** _____

As a personal representative, I have the authority to act for the individual because I am the individual's

_____.

I acknowledge that by signing below, that I have received the ADVANCED SURGICAL CARE P.C.'s Notice of Privacy Practices and Notice of Individual Rights.

***Patient Signature:** _____ **Date:** _____

E- Prescribing

E- prescribing **(electronic prescribing)** is a technology framework that allows physicians and other medical practitioners to write and send prescriptions to a participating pharmacy electronically instead of using handwritten, faxed notes, or calling in prescriptions.

Wireless Calls and Appointment Reminders

If at any time I provide a wireless telephone number or email address at which I may be contacted, I consent to receive calls (including autodialed and prerecorded messages), text messages/emails, at that wireless number/email address **from Advanced Surgical Care, P.C.,** its successors and assigns, and the affiliates, agents and independent contractors, including services and collection agents, regarding my account, the services rendered or my related financial obligations.

Patient Consent

By signing this form, you are agreeing that **Advanced Surgical Care, P.C.,** may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes. You also consent to receive wireless telephone calls as described above.

***Patient Signature:**_____ **Date:** _____

ADVANCED SURGICAL CARE
MEDICAL HISTORY FORM

DATE: _____ **Patient Name:**_____ **DOB:**_____

Home Phone:_____ **Cell #**_____ **Cell Carrier** _____

Reason for today's visit:_____ **When did problem start?**_____

Is this problem work related? Y or N **Date of Injury:** _____

Family Physician: _____

Physician who referred you? _____

Medication	Dosage	How many times per day do you take it?
Do you take Aspirin? Y/N		

DRUG ALLERGIES: **YES or NO** **(If yes, please list below)**

_____

WHICH PHARMACY DO YOU USE? _____
(Include Name of Pharmacy and location)

MEDICAL HISTORY

Neuro	**Yes**	**No**		**Surgical History**	**Yes**	**No**
Stroke?(Z8693)			**When?**	Cardiac Bypass?		
Seizure Disorder?				Cardiac Stents?		
Heart Disease	**Yes**	**No**		Appendectomy?		
Heart Attack? (Z8674)			**When?**	Tonsillectomy?		
Heart Blockage? (I051)				Gallbladder?		
Heart Valve Disease? (I051)				C-Section?		
Heart Rhythm Disease?				Hernia Repair?		
Peripheral Arterial Disease?(I7300)				Breast Implants?		
High Blood Pressure? (I10)				Breast Biopsy?		
Congestive Heart Failure? (I5020)				Tubal Ligation?		
Blood Thinners?			**Medication?**	Hysterectomy?		
Lung Disease	**Yes**	**No**		EGD?		
COPD (J441)/Emphysema (J438)?				Colonoscopy?		
Asthma? (J4520)						
Bronchitis? (J440)						
Lung Cancer? L-(C3482) R-(C3481)						
Kidney Disease						
Stones? (Z87442)						
Kidney Failure?(N178)						
Kidney Cancer? R-(C641) L- (C642)				Other Diseases?		
Gastrointestinal	**Yes**	**No**				
Reflux? (K210)						
Ulcers?						
Irritable Bowel Syndrome? (K589)						
Colitis? (K551)						
Diverticulosis?						

MEDICAL HISTORY

Esophageal Cancer?				
Colon Cancer?				
Other Illnesses	**Yes**	**No**		
HIV?				
Hepatitis?				
Diabetes? (E119)				
High cholesterol? (E78.2)				

SOCIAL HISTORY

	YES	NO	
Do you smoke?			How much per day? For how many years?
Have you ever been a smoker?			How much per day? For how many years?
Do you drink alcohol?			Daily Frequently Occasionally Socially Rarely Never
Occupation?			
Are you disabled?			Why?
Marital Status			Married Single Divorced Widowed

IMMEDIATE FAMILY HISTORY

	YES	NO		RELATIONSHIP TO YOU
Breast Cancer?				
Colon Cancer?				
Any form of Cancer?			What kind?	
Heart Disease? (Z8249)				
High Blood Pressure?				
Stroke? (Z823)				
Diabetes? (Z833)				

SYMPTOMS OR PROBLEMS

General:	Yes	No		**Gastrointestinal:**	Yes	No	
Fever/chills (R5081/R6883)				Abdominal pain			**Where?**
Fatigue (R5383)				Nausea (R110)			
Abnormal Bleeding				Vomiting (R1111)			
Bruising				Blood in vomit? (K920)			
Weight Loss (R634)				Difficulty swallowing (R4702)			
Weight Gain (R635)				Heartburn (R12)			
Neurological:				Diarrhea (K591)			
Headaches (R51)				Constipation (K5901)			
Visual changes (H543)				Change in bowel habits (R194)			
Blindness (H540)				Blood in stool (K921)			
Hearing loss (H906)				**Genitourinary:**			
Deafness (H900)				Painful urination			
Seizures				Frequency/urgency(R3915)			
Fainting/blacking out				Difficulty controlling bladder			
Tremor				Urinate after bedtime (R351)			
Dizziness(R42)/vertigo				Blood in urine (R312)			
Numbness				Penile/Vaginal discharge			
Weakness(R531)				**Musculoskeletal:**			
Loss of Balance				Muscle pain			
ENT:				Joint pain			**Where?**
Earache				Joint Stiffness			**Where?**
Sore Throat				Joint Swelling			**Where?**
Hoarseness				**Skin:**			
Hay Fever Symptoms				Changes in skin lesions			
Cardiovascular:				Rash			
Chest pain				Ulcers			
Abnormal heart beat (R000)				**Endocrine:**			
Shortness of breath: (R0602)				Intolerance to cold			
Shortness of breath at rest?				Intolerance to heat			
Shortness of breath with exercise?				Hair loss (L658)			
Shortness of breath wake you up at night?				Abnormal hair growth			
Sleep on more than one pillow?				Jitteriness			
Pain in legs when walking?			**Where?**	Abnormal sweating			
How far can you walk?				Hot flashes			
Leg swelling left (R2242) right (R2241)				**Psychological:**			
Respiratory:				Anxiety (F411)			
Wheeze (R062)				Depression			
Cough (R05)				Panic attacks (F410)			
Sputum production? (R093)				Hallucinations			
Bloody sputum? (R042)							

ADVANCED SURGICAL CARE, P.C.

DAVID T. COZART, M.D., F.A.C.S.

DAVID S. THERRIEN, M.D., F.A.C.S

1120 S. Jackson Hwy., Suite 203

Sheffield, AL 35660

P: 256-314-6947

F: 256-314-6902

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ **Date of Birth:** _____

Previous Name: _____ **SSN:** _____

I _____ request and authorize _____

to release healthcare information of the patient named above to:

David T. Cozart, M.D., F.A.C.S. OR David S. Therrien M.D., F.A.C.S

This request and authorization applies to:

Healthcare Information relating to the following treatment, condition, or date(s): _____

_____

All Healthcare Information

Other

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuein, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ **Date signed:** _____

THIS AUTHROIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED