

Surgical Care Associates
Patient Information

Name _____ Age _____ Acct # _____

Is your address the same as your last visit: Yes No If No, please advise the receptionist.

Do you have any new phone numbers? Yes No _____

Has your health insurance changed since your last visit? Yes No If yes, please give the receptionist your new health insurance card.

Who is your primary care doctor? _____

Do you have other referring physicians? _____

Why are you seeing the doctor today? _____

Have you experienced any condition listed below: if yes, please explain

Coronary Artery Disease _____

Kidney Failure _____

Chronic Lung Disease _____

Stroke _____

Sleep Apnea _____ Use or prescribed CPAP? _____

Excessive bleeding from operation _____

Blood clots, Deep Vein Thrombosis (DVT), Pulmonary Emboli (PE) _____

Do you have any other new medical conditions? _____

Have you had any operations, angiograms, angioplasties or cardiac cath since your last visit? _____

Have your medications changed? Yes No If you have a list, please give to the receptionist

Allergies: _____

Immunization History (include date last vaccinated)

Influenza _____

Pneumonia _____

Hepatitis _____

Tetanus _____

Smoking

Current every day smoker

Current some day smoker

Former Smoker

Never Smoked

Date of last colonoscopy _____

Date of last mammogram _____

Height _____ Weight _____

We are now required to gather the following information:

Ethnicity Hispanic or Latino Nonhispanic or Latino

Race: Asian Black/African American Hispanic/Latino Native Hawaiian or other Pacific Island

White/Caucasian American Indian or Alaska Native

Preferred Language English French Italian Japanese Korean Portuguese Russian

Spanish Chinese

I hereby authorize the release of any medical information necessary to process my insurance. I authorize payment directly to the provider of service and I understand that I am financially responsible for my copays, coinsurance and deductibles as well as any services not deemed medically necessary by my insurance company.

Signature: _____ Date: _____