Walters Surgical Associates

PATIENT DEMOGRAPHIC INFORMATION

Full Legal Name: _____ SS #:_____

Address: _____
STREET CITY STATE ZIP CODE

Home Telephone: _____ Cell Phone:_____ Work Phone:_____

Date of Birth: _____ Age:_____ Sex:_____ Race:_____ Marital Status:_____

Email Address: _____

Employer: _____ Work Phone:_____

WHO IS AUTHORIZED TO RECEIVE YOUR MEDICAL INFORMATION?

_____

FINANCIAL RESPONSIBILITY

Full Legal Name: _____ SS #:_____

Date of Birth:_____ Sex:_____ Marital Status:_____ Home Phone:_____

Cell Phone: _____ Work Phone:_____

Occupation: _____ Relationship to Patient:_____

EMERGENCY NOTIFICATION

PERSON TO NOTIFY IN CASE OF AN EMERGENCY, IF OTHER THAN INDIVIDUAL NAMED AS PATIENT INFORMATION

RELEASED TO_____

Relationship to Patient: _____ Phone Number:_____

INSURANCE INFORMATION

Please submit a copy of insurance card(s) to Receptionist.

CONSENT

I consent to treatment necessary for the care of the above named patient.
I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
I allow fax transmittal of my medical records, if necessary.
I acknowledge full financial responsibility for services rendered by WALTERS SURGICAL ASSOCIATES, PA.
I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
I understand that attorney representation does not constitute payment of this account and that I am responsible for the balance in full regardless of representation.
I authorize and request that insurance payments be made directly to WALTERS SURGICAL ASSOCIATES, PA.
I have read and fully understand that above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Signature:_____ Date:_____

Walters Surgical Associates
PERSONAL HISTORY

Patient Name: _____

Date: _____

Family or Referring Doctor: _____

Current Medical Problem:

_____

_____

Please circle all that apply:

Diabetes	Liver Disease	Kidney Disease	Stroke
Asthma	Hypertension	Alcoholism	TB
Heart Disease	Lung Disease	Ulcers	Gallstones

Have you had surgery before? ❒ Yes ❒ No

When? _____ What kind? _____

Use of alcohol: ❒ Never ❒ Rarely ❒ Moderate ❒ Daily

Use of tobacco: ❒ Never ❒ Daily Packs per day_____

ALLERGIES: _____

Pharmacy: _____

CURRENT MEDICATIONS:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you have or know of any blood relatives who have had...?
(please circle and give relationship)

Breast Cancer _____ Colon Cancer _____

Lung Cancer _____ Other _____

Walters Surgical Associates

Patient Name: _____ Date: _____

System Review:

*CONSTITUTIONAL SYMPTOMS

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes

*HEADACHES

Eye disease or injury	No	Yes
Wear glasses/contact lenses	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes

*EARS / NOSE / MOUTH / THROAT

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problem or rhinitis	No	Yes
Nose bleeds	No	Yes
Mouth Sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

*CARDIOVASCULAR

Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Shortness of breath with walking or lying flat	No	Yes
Swelling of feet, ankles or hands	No	Yes

*RESPIRATORY

Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

*GASTROINTESTINAL

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements or constipation	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain or heartburn	No	Yes
Peptic ulcer (stomach or duodenal)	No	Yes

*GENITOURINARY

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change in force of strain when urinating	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Male - testicle pain	No	Yes
Female - pain with periods	No	Yes
Female - irregular periods	No	Yes
Female - vaginal discharge	No	Yes

Female # pregnancies _____ # miscarriages _____

Female - date of last pap smear _____

*MUSCULOSKELETAL

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

*INTEGUMENTARY (skin, breast)

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

*NEUROLOGICAL

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes
Head injury	No	Yes

*PSYCHIATRIC

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

*ENDOCRINE

Glandular or hormone problem	No	Yes
Thyroid disease	No	Yes
Diabetes	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming drier	No	Yes
Change in hat or glove size	No	Yes

*HEMATOLOGICAL/LYMPHATIC

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

*ALLERGIC/IMMUNOLOGIC

History of skin reaction to:

Penicillin or other antibiotics	No	Yes
Morphine, Demerol, or other narcotics	No	Yes
Novocaine or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxin or other serums	No	Yes
Iodine, methiolate or other antiseptic	No	Yes

Other drugs/medications _____

Known food allergies _____

Physician Signature _____ **Date** _____

Walters Surgical Associates, PA

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Ronald M. Walters, M.D., F.A.C.S.
Registered Vascular Technologist
General, Thoracic and
Vascular Surgeon

David L. Greco, M.D., F.A.C.S.
General, Thoracic and
Vascular Surgeon

Andrew C. Lin, M.D.
General, Thoracic, and
Bariatric Surgeon

HIPAA Notice of Privacy Practices

We are required to have you sign an acknowledgement stating you have been informed of the HIPAA Notice of Privacy Practices. This acknowledgement also gives us consent to use your information to treat you and receive payment for these services.

Signature below is only an acknowledgement that you have received this notice of Privacy Practices:

Signature: _____ **Date:** _____

Financial Consent

I consent to treatment necessary for the care of the presenting patient. I authorize the release of all medical records to referring and family physicians, unless indicated otherwise, and to my insurance company, if applicable. I allow fax transmittal of my medical records, if necessary. I acknowledge full financial responsibility for services rendered by **WALTERS SURGICAL ASSOCIATES, P.A.**

I further understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made PRIOR to treatment. I understand that attorney representation does not constitute payment of this account and that I am responsible for the balance, IN FULL, regardless of representation. I authorize and request that insurance payments be made directly to **WALTERS SURGICAL ASSOCIATES, P.A.**

I have read and fully understand the above consent for treatment, financial responsibility, release of information and insurance authorization.

Signature: _____ **Date:** _____