Confidential Information for Surgery

Patients Full Name_____ Date_____

SS#_____ Date of Birth_____ Age_____ Sex_____

Street Address_____

City_____ State_____ Zip Code_____

Home #_____ Work #_____ Other #_____

Employer Name_____ Address_____

(If under 18 yrs of age)
Name of Person Responsible for Bill_____ Relationship_____

SS #_____ Date of Birth_____ Phone #_____

Address (if different from patient)_____

Medicaid #_____ **Medicare #**_____

MEDICAL PRIMARY INSURANCE COVERAGE

Name of Policy Holder_____ Employer_____ Phone #_____

SS #_____ Date of Birth_____ Relationship to Patient_____

Name of Policy_____ ID #_____ Group #_____

Claim Address_____ Phone #_____

DENTAL PRIMARY INSURANCE COVERAGE

Name of Policy Holder_____ Employer_____ Phone#_____

SS #_____ Date of Birth_____ Relationship_____

Name of Policy_____ ID #_____ Group #_____

Claim Address_____ Phone #_____

(The patient is responsible for filing any additional insurance other than the primary coverage.)

PLEASE LIST SOMEONE TO CONTACT IN CASE OF EMERGENCY:

Name_____ **Phone #**_____

PLEASE READ:

1. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DR. JOHN C. SOWELL/DR. ANN HOLZHAUER OF BENEFITS DUE ME FOR THE SERVICES AS DESCRIBED. I UNDERSTAND I AM FINACIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS AUTHORIZATION. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION RELATING TO THIS CLAIM.
2. I AGREE TO A CONSULTATION AND X-RAYS WITH DR. SOWELL/DR. HOLZHAUER PRIOR TO MY TREATMENT OR SURGERY. TREATMENT MAY INVOLVE THE USE OF LOCAL OR GENERAL ANESTHESIA. I RECOGNIZE THAT RISK CAN BE INVOLVED IN BOTH SURGICAL PROCEDURES AND ANESTHESIA.
3. IT IS THE AUDITOR'S POLICY FOR PATIENTS TO PAY FOR CONSULTATION, DIAGNOSTIC AND SURGICAL PROCEDURES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. IF ACCOUNTS ARE 60 DAYS PAST DUE THEY WILL BE TURNED OVER TO OUR AUDITOR FOR COLLECTION.

SIGNATURE: _____

HEALTH HISTORY

1. GENERAL HEALTH: _____ GOOD _____ FAIR 2. DO YOU WEAR CONTACT LENS? _____ YES _____ NO

3. CURRENTLY UNDER PHYSICIAN'S CARE FOR _____

4. CURRENT MEDICATIONS, DRUGS, PILLS _____

5. MEDICATION ALLERGIES _____

6. SERIOUS ILLNESS _____

7. PREVIOUS NON-SURGICAL HOSPITALIZATIONS (reason for admission) _____

8. PREVIOUS SURGERY _____

9. PREVIOUS GENERAL ANESTHESIA (put to sleep) _____

10. HAVE YOU EVER USED OR ABUSED DRUGS (alcohol, marijuana, narcotics, sedatives, cocaine, any other substance)? _____

11. ANY OTHER MEDICAL ILLNESS OR HEALTH CONDITION THAT MAY AFFECT OUR PROVIDING APPROPRIATE CARE FOR YOU _____

12. HAVE YOU EVER HAD ANY OF THE FOLLOWING:

1. HEART DISEASE	YES	NO		YES	NO
A. Heart Murmur	( )	( )	4. KIDNEY or LIVER DISEASE	( )	( )
B. High Blood Pressure	( )	( )	A. Hepatitis	( )	( )
C. Rheumatic Fever	( )	( )	5. Diabetes (sugar)	( )	( )
D. Heart Attack	( )	( )	6. Abnormal Bleeding	( )	( )
E. Stroke	( )	( )	7. HAVE YOU EVER TAKEN	( )	( )
F. Heart Disease at Birth	( )	( )	A. Blood Thinners	( )	( )
G. Chest Pain	( )	( )	B. Cortisone (Steroids)	( )	( )
2. LUNG DISEASE			C. Digitalis (Digoxin)	( )	( )
A. Asthma	( )	( )	D. Nitroglycerin	( )	( )
B. Emphysema	( )	( )	8. ARE YOU PREGNANT	( )	( )
C. Bronchitis (significant)	( )	( )	9. THYROID GLAND DISORDER	( )	( )
D. Tuberculosis	( )	( )	10. SEIZURE DISORDER	( )	( )
E. Shortness of Breath	( )	( )	11. GLAUCOMA *(increased pressure in the eye)*	( )	( )
3. DIGESTIVE DISORDER	( )	( )	12. EMOTIONAL OR NERVOUS CONDITION	( )	( )

13. HAVE YOU OR ANY MEMBER OF YOUR FAMILY HAD AN UNUSUAL REACTION TO BEING PUT TO SLEEP? _____

14. DO YOU HAVE A COUGH OR A COLD? _____ 15. HOW LONG SINCE YOU LAST ATE OR DRANK ANYTHING? _____

16. NAME OF PERSON REFERRING YOU TO THIS OFFICE _____

17. REASON FOR THIS VISIT _____

18. DENTIST _____ ADDRESS _____

PHYSICIAN _____ ADDRESS _____

FOR OFFICE USE ONLY: _____