PATIENT MEDICAL HISTORY

DATE _____

NAME _____ DATE OF BIRTH _____

FAMILY PHYSICIAN _____ LAST VISIT _____

ADDITIONAL PHYSICIAN'S THAT YOU WOULD LIKE TO RECEIVE A COPY OF YOUR VISIT SUMMARY:

1. _____ 2. _____

REASON FOR TODAY'S APPT _____

DID YOU HAVE ANY TESTS _____ IF SO, WHAT KIND AND WHERE _____

_____

DRUG ALLERGIES: _____

MEDICATIONS:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

DO YOU SMOKE? NO YES PACKS PER DAY _____ YRS SMOKED _____

IF NO, HAVE YOU EVER SMOKED? NO YES

PACKS PER DAY _____ YRS SMOKED _____ YEAR QUIT _____

DO YOU DRINK ALCOHOL? NO YES - HOW OFTEN? _____

ALL PREVIOUS SURGERY INCLUDING ANY BY OUR OWN PHYSICIANS: APPROXIMATE DATE

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

NAME _____ DATE _____

PERSONAL AND FAMILY HISTORY AND CURRENT ILLNESS:

PLEASE INDICATE ALL THAT APPLY AND RELATIONSHIP TO PATIENT IF OTHER THAN YOURSELF.

	YES	NO	RELATIONSHIP TO PATIENT
ALZHEIMER'S DISEASE	___	___	_____
ANEMIA	___	___	_____
ANEURYSM ~ LOCATION _____	___	___	_____
ANGINA	___	___	_____
ANXIETY / DEPRESSION	___	___	_____
ASTHMA	___	___	_____
ARTHRITIS ~ OSTEO	___	___	_____
~ RHEUMATOID	___	___	_____
BENIGN PROSTATIC HYPERTROPHY	___	___	_____
BLOOD DISORDER, TYPE _____	___	___	_____
BRONCHITIS	___	___	_____
CNS TUMORS	___	___	_____
CANCER ~ TYPE _____	___	___	_____
CAROTID ARTERY DISEASE	___	___	_____
COPD	___	___	_____
CIRRHOSIS	___	___	_____
COLITIS	___	___	_____
CONGESTIVE HEART FAILURE (CHF)	___	___	_____
CORONARY ARTERY DISEASE (CAD)	___	___	_____
CROHN'S DISEASE	___	___	_____
DEEP VEIN THROMBOSIS (DVT)	___	___	_____
DIABETES JUVENILE ___ ADULT ___			
~ INSULIN-DEPENDENT	___	___	_____
~ NON INSULIN-DEPENDENT	___	___	_____
EMPHYSEMA	___	___	_____
PROSTATE DISEASE	___	___	_____
EPILEPSY	___	___	_____
FAINTING SPELLS	___	___	_____
FIBROMYALGIA	___	___	_____
HEART~ ATRIAL FIBRILLATION	___	___	_____
~ MURMUR	___	___	_____
~ PALPITATIONS	___	___	_____
~ PACEMAKER / DEFIBRILLATOR	___	___	_____
~ VALVE DISEASE	___	___	_____
HEART ATTACK (MI)	___	___	_____
HEPATITIS	___	___	_____
HYPERCHOLESTEROLEMIA	___	___	_____
HYPERGLYCEMIA / HYPOGLYCEMIA	___	___	_____
HYPERTENSION	___	___	_____
HYPERTHYROIDISM / HYPOTHYROIDISM	___	___	_____
KIDNEY ~ DISEASE	___	___	_____
~ STONES	___	___	_____
MULTIPLE SCLEROSIS (MS)	___	___	_____
PARKINSON'S DISEASE	___	___	_____
PERIPHERAL VASCULAR DISEASE (PVD)	___	___	_____
PHLEBITIS	___	___	_____
PULMONARY EMBOLISM (PE)	___	___	_____
RHEUMATIC FEVER	___	___	_____
SEIZURE DISORDER	___	___	_____
VARICOSE VEINS	___	___	_____
VERTIGO	___	___	_____

PATIENT CONSENT FORM

NYS law prohibits our medical office staff from speaking with any individual other than yourself regarding any of your medical health information. This includes information regarding your condition, medication, appointments or test results. **This is to protect your rights as a patient that your records are kept confidential.** Should you prefer that any person be able to discuss your medical chart/condition on your behalf, this form should be completed and signed with a witness signature.

I, _____ give South Towns Surgical Associates my permission to speak
(patient name)

with _____ regarding any of my health information, including but not
(person's name & relationship)

limited to, test results, appointments, physician advice and treatment.

I have read and understand the above information.

_____ _____
(patient signature) (date)

_____ _____
(witness signature) (date)

I give South Towns Surgical Associates authorization to leave a message on my voice mail/answering machine regarding any of my health information.

_____ _____
(patient signature) (date)

TO ALL OF OUR VALUED SOUTH TOWNS SURGICAL PATIENTS:

At South Towns Surgical we are doing our very best to keep up with the rapid changes to health care plans. To help us provide the quality of care that you have come to expect from us, we would like to make you aware of the patient policies that must be adhered to.

We are no longer able to bill you for your co-payment. **Your co-pay/coinsurance must be paid before you are seen by your Provider or we will need to reschedule your appointment.** Due to policy provisions in your insurance contract with your insurance carrier and under terms of the federal anti-kickback laws, we are legally prohibited from writing off deductibles, co-payments and patient responsibility co-insurance as directed by your insurance carrier. This is a contractual obligation that we have with the local health care plans and by asking us to waive your co-payment or not bill it to you, we are in direct violation of our agreement which could result in termination of our relationship with the health care plan.

Please do not put our Providers in an uncomfortable situation by asking them about your bills or payments. We have a Billing Office Staff that our Physicians have provided to work with you regarding your financial obligations to South Towns Surgical . It is ultimately your responsibility to understand your specific coverage that is provided under the health plan that you choose to enroll into.

UNPAID BALANCES: If, for any reason, you maintain an unpaid balance on you account up to 90 days and fail to make payment arrangements with us, your account will be assessed a $5 charge per statement. After 90 days, your account will be turned over to a collection agency and a $50.00 charge will be added and proceedings will begin.

MISSED APPOINTMENTS: If you must cancel your appointment, we ask that you kindly give 24 hours notice. Please be advised that any cancellation within 24 hours will be charged $25.00 cancellation fee. If you fail to keep your appointment, you will be charged a $50.00 No Show Fee.

Thank you for your cooperation.

The Doctors and Staff at South Towns Surgical Associates.

_____ _____

(name) (date)