Medical History
Review of Systems

Date of Birth _____ Married ☐ Divorced ☐ Single ☐

Tobacco Use Current ☐ amount _____ Past use ☐ amount _____ Quit

Alcohol Use Current ☐ amount _____ Past use ☐ amount _____ Quit

Medication Allergies_____

Medical History

☐ Alcoholism	☐ High Blood Pressure	☐ Stroke
☐ Anemia	☐ Kidney Disease	☐ Suicide Attempt
☐ Asthma	☐ Liver Disease	☐ Thyroid Disease
☐ Cancer	☐ Hepatitis	☐ Tuberculosis
☐ Diabetes	☐ Lung Disease	☐ Ulcers Stomach / Duodenum
☐ Depression	☐ Mental Illness	☐ Ulcerative colitis or Crohn's disease
☐ Epilepsy / Seizures	☐ Osteoarthritis	☐ HIV / Immune Disease
☐ Glaucoma	☐ Osteoporosis	☐ _____
☐ Heat disease	☐ Pulmonary Embolus	☐ _____

When was your last Pneumonia Vaccine? _____

Past Surgical History (type of surgery and date it was done)

_____

_____

_____

_____

Family History

Mother_____

Father_____

Siblings_____

Medications (Dose and how often it is taken)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Review of Systems

(Please check if you have had these in the past 3 months)

Constitutional

- ☐ Weight Loss
- ☐ Fatigue
- ☐ Fever/ Chills

Eyes

- ☐ Glasses/ contacts
- ☐ Eye pain
- ☐ Double vision
- ☐ Cataracts

Ear, Nose, Throat

- ☐ Difficulty hearing
- ☐ Ringing in ears
- ☐ Vertigo
- ☐ Sinus Trouble
- ☐ Nasal Congestion
- ☐ Frequent sore throat

Cardiovascular

- ☐ Heart murmur
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Dizziness
- ☐ Fainting
- ☐ Shortness of breath
- ☐ Difficulty laying flat
- ☐ Swelling in feet/ ankles

Endocrine

- ☐ Hair loss
- ☐ Heat/cold intolerance
- ☐ Frequent urination

Respiratory

- ☐ Cough
- ☐ Coughing blood
- ☐ Wheezing
- ☐ Frequent bronchitis

Gastrointestinal

- ☐ Heartburn/ reflux
- ☐ Nausea/ vomiting
- ☐ Contispation
- ☐ Diarrhea
- ☐ Right upper abdomen pain
- ☐ Blood in stools or black stools
- ☐ Jaundice
- ☐ Abdominal pain

Genitourinary

- ☐ Burning/frequency
- ☐ Nocturnal urination
- ☐ Blood in urine
- ☐ Erectile Dysfunction
- ☐ Bladder leakage

Psychiatric

- ☐ Anxiety/ depression
- ☐ Mood swings
- ☐ Insomnia
- ☐ Hallucinations/ hearing voices

Hematology/ Lymph

- ☐ Easy Bleeding/ bruising
- ☐ Bleeding gums
- ☐ Enlarged lymph nodes

Musculoskeletal

- ☐ Joint pain/ swelling
- ☐ Stiffness
- ☐ Muscle pain
- ☐ Back pain

Skin

- ☐ Moles that have changed
- ☐ Rash / sores

Neurologic

- ☐ Loss of strength
- ☐ Numbness
- ☐ Headaches
- ☐ Tremors
- ☐ Memory loss

Female only

Last mammogram _____

Last PAP _____

Last period _____

2013 Patient Information Sheet
Advanced Laparoscopic and General Surgery

Patient Name_____**Prefer to be called**: _____
First Name Middle Initial Last Name

Address: _____ **City:** _____ **State:** _____ **Zip:**_____

Home phone: (____)_____ **Work phone**: (____)_____ **Cell Phone:** (____)_____

SSN:_____ **Marital Status:** _____ **Date of Birth**:_____ **Gender:** ☐ F ☐ M

Employers Name:_____ **Occupation:**_____

New Patients to the Practice: Who may we thank for your referral to our practice?
☐ Dr. (_____) ☐ Fa
☐Other (Please Specify): _____

HEALTH INSURANCE INFORMATION -OR- ☐☐☐ SELF PAY

(Although we have copied your insurance card, we still need you to complete all of the information below)

PRIMARY INS: _____ **Eff. Date:**_____ **Copay Amt.: $**_____

Policy Holder Name: _____**DOB:** _____ **M /F:** ____

If same as above, please write "same" on this line & disregard the primary insurance section

Policy Holder Address (if different from above):_____

Policy Holder Employer: _____**Employer Ph#:** (_____) _____

Relationship to Policy Holder: _____**Policy Holder SS#:** _____
Policy Holder ID: _____**Group #:**_____

SECONDARY INS: _____(if Medicare is 2ndary, please read below) **Eff. Date**:_____
Medicare Patient's Only: If Medicare is your secondary insurance, please list a reason why Medicare is the secondary insurance. Information needed in order to file your claim with Medicare. Reason: _____

Policy Holder Name: _____**DOB:** _____ **M /F:** ___

Policy Holder Address (if different from above):_____

Policy Holder Employer: _____**Employer Ph #:** (_____) _____

Relationship to Policy Holder: _____**Policy Holder SS#:** _____

Policy Holder ID: _____**Group#:**_____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ **Relationship to Patient:**_____
Home Ph#:_____**Work Ph#:**_____**Alt. Ph#**_____

Do you have a living will or a durable power of attorney? (circle one) Yes No
****If yes, please provide the office a copy****

The undersigned patient or individual acting on behalf of the patient agrees as follows:

1. I authorize **HealthONE** to render needed treatment to the above named patient.
2. I authorize **HealthONE** to release any information required for payment of claims.
3. I authorize my insurance benefits to be paid directly to the treating physician, realizing I am responsible to pay non-covered and unauthorized services and I hereby authorize the release of pertinent medical information to insurance carrier.
4. I understand that I am responsible for all charges incurred through **HealthONE**

Email Address_____ ☐ **NO EMAIL**

Signature:_____ **Date**:_____

Advanced Laparoscopic and General Surgery

Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following treatment::

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **HealthONE /Skyline Internal Medicine** may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that **HealthONE / Skyline Internal Medicine** will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **HealthONE /Skyline Internal Medicine.**

I acknowledge that I have been given the **HealthONE / Skyline Internal Medicine** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.
Patient Initial: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient (or Responsible Party) Signature **Date**

How Can We Reach You?
PHONE MESSAGE CONSENT

Your provider will at times need to contact you. By filling out the information below we will be better able to serve you.

Name: _____

In an effort to protect your privacy, we have developed a policy on leaving medical care messages:

- We will ***NOT*** leave messages with anyone except the patient or legal guardian.
- We will ***NOT*** leave any messages on a voice mail or answering machine.

UNLESS
WE HAVE YOUR WRITTEN PERMISSION TO DO SO.

Please read below and consider carefully whom you authorize to have access to protected information regarding your care.

I, _____ give HealthONE my permission to speak with and/or leave messages regarding my medical care and/or billing with the following. I fully understand that this consent will remain valid until revoked in writing.

My **Home** answering machine: #_____ Initials: _____

My **Cell** voice mail: #_____ Initials: _____

My **Office/Work** voice mail: #_____ Initials: _____

Other Contacts:

Contact Name: _____ Relationship: _____

Phone#: _____ Initials:_____

Contact Name: _____ Relationship: _____

Phone#: _____ Initials:_____

Contact Name: _____ Relationship: _____

Phone#: _____ Initials:_____

Signature: _____ Date: _____