

Progressive Surgical Associates

PATIENT INFORMATION

_____ NAME (FIRST, MIDDLE, LAST)	_____ DATE OF BIRTH
_____ STREET ADDRESS	_____ SOCIAL SECURITY NUMBER
_____ CITY, STATE, ZIP	_____ HOME PHONE
_____ E-MAIL	_____ CELL PHONE
_____ PATIENT EMPLOYER	_____ EMPLOYER PHONE
_____ EMERGENCY CONTACT AND RELATIONSHIP	_____ EMERGENCY CONTACT PHONE

INSURANCE INFORMATION

_____ PRIMARY INSURANCE COMPANY	_____ NAME OF POLICY HOLDER
_____ RELATIONSHIP TO POLICY HOLDER	_____ DATE OF BIRTH OF POLICY HOLDER
_____ WORK PLACE OF POLICY HOLDER	

_____ SECONDARY INSURANCE COMPANY	_____ NAME OF POLICY HOLDER
_____ RELATIONSHIP TO POLICY HOLDER	_____ DATE OF BIRTH OF POLICY HOLDER
_____ WORK PLACE OF POLICY HOLDER	

Staff only: _____

Progressive Surgical Associates

NEW PAYMENT POLICY (PLEASE READ IN ENTIRETY)

Progressive Surgical Associates has implemented a new policy for all patients. If you wish to be seen by our practice, we will be requesting your credit/debit card information to keep on file to be used to cover any charges not paid by your insurance. Patients will still be expected to pay known co-pays, co-insurance and any applicable deductible at the time of service. If a balance remains after your insurance has paid, you will receive two statement for services, mailed on the 1st and the 15th of the month. Payment is due 30 days from the first statement.

It will be the responsibility of the patient to contact our office if there is any question regarding your claim, amount due, to set up a payment plan, or provide an alternate form of payment before 30 days from the first statement. If we do not hear from you within 30 days of the first statement, the balance on your account will be charged to your credit/debit card on file.

Your credit/debit information will be kept with the highest level of security and will only be used for your medical expenses.

Your understanding of and patience with this new policy is very important. To be clear, no charges will be placed on your credit card until after your claim is settled with your insurance carrier and a statement has been mailed to you. If we do not hear from you within 30 days after this statement has been sent, we will charge your credit card.

Patient's Name: _____ Date of Birth ____/____/____

Cardholder's Name: _____

Card Type: ___ Visa ___ MasterCard ___ Discover ___ American Express

Credit Card Number: _____

Expiration Date: ____/____ CVV: _____ Billing Zip Code: _____

Signature: _____ Date: ____/____/____

Credit/Debit Card Consent Form

My signature above authorizes Progressive Surgical Associates to maintain my credit/debit card information to be used for charges that are my responsibility, after insurance has paid their portion. I understand that this form is valid until I provide written notice that it is revoked (after any balance is paid in full). I also understand that if I change to a new credit/debit card, I will supply Progressive Surgical Associates with the new credit/debit card information.

RACE, ETHNICITY, AND LANGUAGE PREFERENCE

RACE

- AMERICAN INDIAN OR ALASKA NATIVE
- ASIAN
- NATIVE HAWAIIAN
- BLACK OR AFRICAN AMERICAN
- WHITE
- HISPANIC
- OTHER RACE _____

ETHNICITY

- HISPANIC
- NON-HISPANIC
- DECLINE TO REPORT

PREFERRED LANGUAGE

- ENGLISH
- INDIAN (INCLUDE HINDI AND TAMIL)
- SPANISH
- POLISH
- OTHER LANGUAGE _____

Progressive Surgical Associates

AUTHORIZATION TO TREAT (Please initial each blank below)

I hereby authorize and consent to treat/care rendered to me by the physician/medical staff. _____

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

I have received and read "Our Financial Policy" and agree to the terms therein. I also understand and agree that such terms may be amended by the Practice from time to time. _____

Additionally, I authorize Progressive Surgical Associates to bill my insurance company on my behalf and accept payment from them directly. I know I am required to make any required co-payment amounts, as well as pay for any charges assigned to my deductible, or non-covered services, including an assistant for surgery. _____

PRIVACY PRACTICES AND AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, where, and why my Protected Health Information (PIH), which may include information regarding HIV/AIDS status or mental health records, may be used or shared. _____

I hereby authorize my insurance carrier to furnish Progressive Surgical Associates any information obtained in the adjudication of any claim in regard to services furnished to me by them. This authorization is valid until rescinded by me in writing. I authorize Progressive Surgical Associates to furnish complete information, including Protected Health Information, requested by my insurance carrier or its intermediaries regarding services rendered. _____

I acknowledge that Progressive Surgical Associates (PSA), the physicians, the nurses, and other PSA staff may obtain and share any or all of my Protected Health Information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern PSA's operations and responsibilities. _____

I further authorize the disclosure of my Protected Health Information to the following individuals/family members:

_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient

NOTICES AND PATIENT COMMUNICATIONS

You expressly consent to be contacted by Progressive Surgical Associates (PSA), or anyone calling on its behalf, for any and all purposes, at any telephone number, or physical or electronic address you provide or which you may be reached, including any wireless telephone number. You agree that PSA may contact you in any way, including calls or prerecorded or artificial voice or text messages delivered by an automatic telephone system dialing system, or e-mail messages delivered by an automatic e-mailing system. You expressly acknowledge that this consent cannot be revoked without prior agreement and acceptance by us. You agree to promptly notify us at any time your contact information changes.

X _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**

I give permission that Progressive Surgical Associates may:

- Leave a detailed message on my home/cell answering machine or voicemail
- Call my workplace phone number and leave a message
- Call my workplace phone number and only speak to me
- None of the above

X _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**

Progressive Surgical Associates

_____ NAME (FIRST, MIDDLE, LAST)	_____ DATE OF BIRTH	
_____ PRIMARY CARE PHYSICIAN	_____ WHO REFERRED YOU HERE TODAY?	_____ CARDIOLOGIST
NAME AND LOCATION OF PREFERRED PHARMACY? _____		

Office only:

CURRENT MEDICATIONS

MEDICATION NAME	DOSAGE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ARE YOU TAKING ANY BLOOD THINNING MEDICATIONS, I.E., PLAVIX, COUMADIN, LOVENOX, ASPIRIN, IBUPROFEN, MOTRIN?
 YES NO IF YES, WHAT? _____

ARE YOU TAKING ANY DIET OR HERBAL MEDICATION?
 YES NO IF YES, WHAT? _____

PAST MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU HAD:

<input type="checkbox"/> ABNORMAL HEART RHYTHM	<input type="checkbox"/> ELEVATED CHOLESTEROL	<input type="checkbox"/> LIVER PROBLEMS
<input type="checkbox"/> ANXIETY	<input type="checkbox"/> GERD/HEARTBURN	<input type="checkbox"/> OSTEOPOROSIS
<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> FIBROMYALGIA	<input type="checkbox"/> PULMONARY EMBOLISM
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> HEART ATTACK	<input type="checkbox"/> SEIZURE
<input type="checkbox"/> AUTOIMMUNE DISEASE	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> STROKE
<input type="checkbox"/> BLEEDING DISORDER	<input type="checkbox"/> HEART FAILURE	<input type="checkbox"/> TUBERCULOSIS
<input type="checkbox"/> BLOOD CLOTS	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> ULCER
<input type="checkbox"/> CANCER, TYPE: _____	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> CHICKEN POX
<input type="checkbox"/> CONGENITAL ABNORMALITY	<input type="checkbox"/> HYPERTHYROID	<input type="checkbox"/> MUMPS
<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> HYPOTHYROID	<input type="checkbox"/> RHEUMATIC FEVER
<input type="checkbox"/> DIABETES	<input type="checkbox"/> KIDNEY FAILURE	<input type="checkbox"/> OTHER: _____

Staff only: _____

DRUG ALLERGIES

PLEASE LIST ANY DRUG ALLERGIES AND REACTION:

PAST SURGICAL HISTORY

- | | | |
|---|---|--|
| <input type="checkbox"/> APPENDECTOMY | <input type="checkbox"/> EGD | <input type="checkbox"/> HYSTRECTOMY (VAGINAL) |
| <input type="checkbox"/> BACK SURGERY | <input type="checkbox"/> GALLBLADDER | <input type="checkbox"/> JOINT REPLACEMENT |
| <input type="checkbox"/> BREAST SURGERY | <input type="checkbox"/> GASTRIC BYPASS / BANDING | <input type="checkbox"/> OVARY REMOVAL |
| <input type="checkbox"/> CATARACTS | <input type="checkbox"/> HEART BYPASS | <input type="checkbox"/> TONSILLECTOMY |
| <input type="checkbox"/> COLON / RECTAL SURGERY | <input type="checkbox"/> HEMORRHOID SURGERY/BANDING | <input type="checkbox"/> OTHER: |
| <input type="checkbox"/> COLONOSCOPY | <input type="checkbox"/> HERNIA REPAIR | |
| <input type="checkbox"/> C-SECTION | <input type="checkbox"/> HYSTERECTOMY (ABDOMINAL) | |

FAMILY HISTORY

DO YOU HAVE A HISTORY OF **CANCER OR HEART DISEASE** IN YOUR FAMILY? PLEASE LIST THE MEMBER AND THEIR CONDITION

Progressive Surgical Associates

SOCIAL HISTORY

MARITAL STATUS: (CIRCLE ONE)				
SINGLE	MARRIED	DIVORCED	SEPERATED	WIDOWED
EDUCATION: (CIRCLE ONE)				
HIGH SCHOOL	COLLEGE	POST – GRADUATE		
OCCUPATION: _____				
YOUR SEXUAL PREFERENCE: (CIRCLE ONE)				
HETEROSEXUAL	HOMOSEXUAL	EITHER	PREFER NOT TO ANSWER	
DO YOU DRINK ALCOHOL?				
<input type="checkbox"/> YES (HOW MUCH? _____)		<input type="checkbox"/> FORMERLY USED ALCOHOL		<input type="checkbox"/> NEVER USED ALCOHOL
DO YOU SMOKE?				
<input type="checkbox"/> CURRENT SMOKER (HOW MUCH? _____)		<input type="checkbox"/> FORMER SMOKER? (QUIT DATE _____)		<input type="checkbox"/> NEVER SMOKED
FOR WOMEN:				
NUMBER OF PREGNANCIES _____		NUMBER OF MISCARRIAGES _____		
NUMBER OF DELIVERIES _____		NUMBER OF ABORTIONS _____		
IN THE PAST 12 MONTHS HAVE YOU USED: (CIRCLE ONE, IF ANY)				
COCAINE	MARIJUANA	SPEED	OTHER: _____	
DO YOU INTAKE ANY OF THE FOLLOWING: (CIRCLE ONE, IF ANY)				
COFFEE	TEA	SODA	CHOCOLATE	

REVIEW OF SYSTEMS

<p>CONSTITUTIONAL SYMPTOMS</p> <p>RECENT WEIGHT CHANGE <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>FEVER <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>FATIGUE <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>HEADACHES <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>DERMATOLOGY</p> <p>RASH OR ITCHING <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>VARICOSE VEINS <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>ENDOCRINE</p> <p>GLANDULAR/HORMONAL PROBLEM <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>HEAT OR COLD INTOLERANCE <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>INSULIN PUMP <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>BREAST CONDITIONS</p> <p>BREAST PAIN <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>BREAST LUMP <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>BREAST DISCHARGE <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>HEMATOLOGIC/LYMPHATIC</p> <p>BLEEDING/BRUISING TENDENCY <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>ANEMIA <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>PHLEBITIS/BLOOD CLOTS IN LEGS <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>PAST TRANSFUSION <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>NEUROLOGICAL</p> <p>CONVULSIONS OR SEIZURES <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>NUMBNESS OR TINGLING SENSATIONS <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>PARALYSIS <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>STROKE OR TIA <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>EYES</p> <p>WEAR GLASSES/CONTACTS <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>BLURRED OR DOUBLE VISION <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>EARS/NOSE/MOUTH/THROAT</p> <p>HEARING LOSS OR RINGING <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>NOSEBLEEDS <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>SORE THROAT OR VOICE CHANGE <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>RESPIRATORY</p> <p>ASTHMA <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>EMPHYSEMA <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>CHRONIC/FREQUENT COUGHS <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>TUBERCULOSIS <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>PNEUMONIA <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>CARDIOVASCULAR</p> <p>HEART MURMUR <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>MITRAL VALVE PROLAPSE <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>RHEUMATIC FEVER <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>CHEST PAIN/ANGINA PECTORIS <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>PALPITATIONS (RAPID HEART BEAT) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>PACEMAKER <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>STROKE <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>HISTORY OF HEART ATTACK <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>GASTROINTESTINAL</p> <p>LOSS OF APPETITE <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>CHANGE IN BOWEL HABITS <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>NAUSEA <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>VOMITING <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>FREQUENT DIARRHEA <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>PAINFUL BOWEL MOVEMENTS <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>CONSTIPATION <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>RECTAL BLEEDING/BLOOD IN STOOL <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>ABDOMINAL PAIN <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>UNINTENTIONAL WEIGHT LOSS <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>JAUNDICE <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>VOMITING BLOOD <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>HISTORY OF LIVER DISEASE <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>MUSCULOSKELETAL</p> <p>JOINT PAIN <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>JOINT STIFFNESS OR SWELLING <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>WEAKNESS OF MUSCLE/JOINTS <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>BACK PAIN <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>PSYCHIATRIC</p> <p>NERVOUSNESS <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>DEPRESSION <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>INSOMNIA <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>ANXIETY <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>GENITOURINARY</p> <p>BLOOD IN URINE <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>INCONTINENCE OR DRIBBLING <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>KIDNEY STONE <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>HEIGHT: _____ ft _____ in</p> <p>WEIGHT: _____ lbs</p> <p>AGE: _____ years</p>
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My signature below signifies that the information provided in this document, which includes my medical history, is true and complete, to the best of my knowledge.

PATIENT SIGNATURE _____ DATE _____