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

EMERGENCY CONTACT AND RELATIONSHIP

EMERGENCY CONTACT PHONE

PATIENT EMPLOYER

PATIENT EMPLOYER PHONE NUMBER

**INSURANCE INFORMATION**

PRIMARY INSURANCE COMPANY

NAME OF POLICY HOLDER

RELATIONSHIP TO POLICY HOLDER

DATE OF BIRTH OF POLICY HOLDER

POLICY HOLDER EMPLOYER

POLICYHOLDER EMPLOYER PHONE NUMBER

SECONDARY INSURANCE COMPANY

NAME OF POLICY HOLDER

RELATIONSHIP TO POLICY HOLDER

DATE OF BIRTH OF POLICY HOLDER

POLICY HOLDER EMPLOYER

POLICYHOLDER EMPLOYER PHONE NUMBER

**RACE/ETHNICIY**

☐ AMERICAN INDIAN OR ALASKA NATIVE

☐ ASIAN

☐ NATIVE HAWAIIAN

☐ BLACK OR AFRICAN AMERICAN

☐ WHITE

☐ HISPANIC

☐ OTHER RACE_____



Staff only: _____

## 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 statements 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.



Staff only: _____

## 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
☐ Send text/SMS messages about medical instructions or collecting payments
☐ None of the above

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



Staff only: _____

NAME (FIRST, MIDDLE, LAST) _____ DATE OF BIRTH _____

PRIMARY CARE PHYSICIAN _____ WHO REFERRED YOU HERE TODAY? _____ CARDIOLOGIST _____

NAME AND LOCATION OF PREFERRED PHARMACY? _____

HEIGHT _____ ft _____ inches WEIGHT_____ lbs AGE _____

**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**:

- ☐ ABNORMAL HEART RHYTHM
- ☐ ANXIETY
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ AUTOIMMUNE DISEASE :_____
- ☐ BLEEDING DISORDER
- ☐ BLOOD CLOTS
- ☐ CANCER, TYPE: _____
- ☐ CONGENTIAL ABNORMALITY
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ ELEVATED CHOLESTEROL
- ☐ GERD/HEARTBURN
- ☐ FIBROMYALGIA
- ☐ HEART ATTACK
- ☐ HEART DISEASE
- ☐ HEART FAILURE
- ☐ HIGH BLOOD PRESSURE
- ☐ HIV/AIDS
- ☐ HYPERTHYROID
- ☐ HYPOTHYROID
- ☐ KIDNEY DISEASE
- ☐ LIVER PROBLEMS
- ☐ OSTEOPOROSIS
- ☐ PULMONARY EMBOLISM
- ☐ SEIZURE
- ☐ STROKE
- ☐ TUBERCULOSIS
- ☐ ULCER : _____
- ☐ OTHER: _____



Staff only: _____

**DRUG ALLERGIES**

PLEASE LIST ANY DRUG ALLERGIES AND REACTION:

_____ _____

_____ _____

**PAST SURGICAL HISTORY**

☐ APPENDECTOMY
☐ BACK SURGERY
☐ BREAST SURGERY
☐ COLON / RECTAL SURGERY
☐ COLONOSCOPY
☐ C-SECTION
☐ EGD (UPPER ENDOSCOPY)
☐ GALLBLADDER
☐ GASTRIC BYPASS / BANDING
☐ HEART BYPASS
☐ HEMORRHOID SURGERY/BANDING
☐ HERNIA REPAIR: _____
☐ HYSTERECTOMY (ABDOMINAL)
☐ HYSTRECTOMY (VAGINAL)
☐ JOINT REPLACEMENT
☐ OVARY REMOVAL
☐ TONSILLECTOMY
☐ OTHER: _____ _____

**FAMILY HISTORY**

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

_____

_____

**SOCIAL HISTORY**

**OCCUPATION:** _____

DO YOU DRINK ALCOHOL?

☐ **YES** (HOW MUCH?_____) ☐ **FORMERLY USED ALCOHOL** ☐ **NEVER USED ALCOHOL**

DO YOU SMOKE TOBACCO?

☐ **CURRENT SMOKER** (HOW MUCH?_____) ☐ **FORMER SMOKER?** (QUIT DATE_____) ☐ **NEVER SMOKED**

FOR WOMEN:

NUMBER OF PREGNANCIES _____ NUMBER OF LIVE BIRTHS _____

IN THE PAST 12 MONTHS HAVE YOU USED: (CIRCLE ONE, IF ANY)

**COCAINE** **MARIJUANA** **SPEED** **OTHER:** _____

Progressive Surgical Associates

## REVIEW OF SYSTEMS

**CONSTITUTIONAL SYMPTOMS**

| | | |
|---|---|---|
| RECENT WEIGHT: GAIN / LOSS (circle) | ☐ YES | ☐ NO |
| FEVER | ☐ YES | ☐ NO |
| FATIGUE | ☐ YES | ☐ NO |
| HEADACHES | ☐ YES | ☐ NO |

**DERMATOLOGY**

| | | |
|---|---|---|
| RASH OR ITCHING | ☐ YES | ☐ NO |
| VARICOSE VEINS | ☐ YES | ☐ NO |

**ENDOCRINE**

| | | |
|---|---|---|
| GLANDULAR/HORMONAL PROBLEM | ☐ YES | ☐ NO |
| INTOLERANCE TO: HEAT / COLD (circle) | ☐ YES | ☐ NO |
| INSULIN PUMP | ☐ YES | ☐ NO |

**BREAST CONDITIONS**

| | | |
|---|---|---|
| BREAST PAIN | ☐ YES | ☐ NO |
| BREAST LUMP | ☐ YES | ☐ NO |
| BREAST DISCHARGE | ☐ YES | ☐ NO |

**HEMATOLOGIC/LYMPHATIC**

| | | |
|---|---|---|
| BLEEDING/BRUISING TENDENCY | ☐ YES | ☐ NO |
| ANEMIA | ☐ YES | ☐ NO |
| PHLEBITIS/BLOOD CLOTS IN LEGS | ☐YES | ☐NO |
| PAST TRANSFUSION | ☐ YES | ☐ NO |

**NEUROLOGICAL**

| | | |
|---|---|---|
| CONVULSIONS OR SEIZURES | ☐ YES | ☐ NO |
| NUMBNESS OR TINGLING SENSATIONS | ☐ YES | ☐ NO |
| PARALYSIS | ☐ YES | ☐ NO |
| STROKE OR TIA | ☐ YES | ☐ NO |

**EYES**

| | | |
|---|---|---|
| WEAR: GLASSES / CONTACTS (circle) | ☐ YES | ☐ NO |
| BLURRED OR DOUBLE VISION | ☐ YES | ☐ NO |

**EARS/NOSE/MOUTH/THROAT**

| | | |
|---|---|---|
| HEARING LOSS OR RINGING | ☐ YES | ☐ NO |
| NOSEBLEEDS | ☐ YES | ☐ NO |
| SORE THROAT OR VOICE CHANGE | ☐ YES | ☐ NO |

**RESPIRATORY**

| | | |
|---|---|---|
| ASTHMA | ☐ YES | ☐ NO |
| EMPHYSEMA | ☐ YES | ☐ NO |
| CHRONIC/FREQUENT COUGHS | ☐ YES | ☐ NO |
| TUBERCULOSIS | ☐ YES | ☐ NO |
| PNEUMONIA | ☐ YES | ☐ NO |

**CARDIOVASCULAR**

| | | |
|---|---|---|
| HEART MURMUR | ☐ YES | ☐ NO |
| MITRAL VALVE PROLAPSE | ☐ YES | ☐ NO |
| RHEUMATIC FEVER | ☐ YES | ☐ NO |
| CHEST PAIN/ANGINA PECTORIS | ☐ YES | ☐ NO |
| PALPITATIONS (RAPID HEART BEAT) | ☐ YES | ☐ NO |
| PACEMAKER | ☐ YES | ☐ NO |
| STROKE | ☐ YES | ☐ NO |
| HISTORY OF HEART ATTACK | ☐ YES | ☐ NO |

**GASTROINTESTINAL**

| | | |
|---|---|---|
| LOSS OF APPETITE | ☐ YES | ☐ NO |
| CHANGE IN BOWEL HABITS | ☐ YES | ☐ NO |
| NAUSEA | ☐ YES | ☐ NO |
| VOMITING | ☐ YES | ☐ NO |
| FREQUENT DIARRHEA | ☐ YES | ☐ NO |
| PAINFUL BOWEL MOVEMENTS | ☐ YES | ☐ NO |
| CONSTIPATION | ☐ YES | ☐ NO |
| RECTAL BLEEDING/BLOOD IN STOOL | ☐ YES | ☐ NO |
| ABDOMINAL PAIN | ☐ YES | ☐ NO |
| UNINTENTIONAL WEIGHT LOSS | ☐ YES | ☐ NO |
| JAUNDICE | ☐ YES | ☐ NO |
| VOMITING BLOOD | ☐ YES | ☐ NO |
| HISTORY OF LIVER DISEASE | ☐ YES | ☐ NO |
| HEARTBURN / ACID REFLUX | ☐ YES | ☐ NO |

**MUSCULOSKELETAL**

| | | |
|---|---|---|
| JOINT PAIN | ☐ YES | ☐ NO |
| JOINT STIFFNESS OR SWELLING | ☐ YES | ☐ NO |
| WEAKNESS OF MUSCLE/JOINTS | ☐ YES | ☐ NO |
| BACK PAIN | ☐ YES | ☐ NO |

**PSYCHIATRIC**

| | | |
|---|---|---|
| NERVOUSNESS | ☐ YES | ☐ NO |
| DEPRESSION | ☐ YES | ☐ NO |
| INSOMNIA | ☐ YES | ☐ NO |
| ANXIETY | ☐ YES | ☐ NO |

**GENITOURINARY**

| | | |
|---|---|---|
| BLOOD IN URINE | ☐ YES | ☐ NO |
| INCONTIENCE OR DRIBBLING | ☐ YES | ☐ NO |
| KIDNEY STONE | ☐ YES | ☐ NO |

**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**_____