GSA
GENERAL SURGERY
ASSOCIATES

Date of Appointment: _____

First Name: _____ Middle Initial: _____ Last Name: _____

SSN: _____ Birthdate: _____ Age: _____ Marital Status _____ ☐ Male ☐ Female

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

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Preferred Method of Contact: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ E-Mail

Employer: _____ Occupation: _____ Work #: _____

Spouse Name: _____ Spouse Phone: _____ Spouse Employer: _____

Additional Emergency Contact: _____ Phone: _____ Relation: _____

Primary Language: ☐ English ☐ Spanish ☐ French ☐ Arabic ☐ Other _____

Race: ☐ American Indian ☐ Asian ☐ African American ☐ White ☐ Other ☐ Decline to Answer

Are you Hispanic or Latino? ☐ Y ☐ N ☐ Decline to Answer

Primary Insurance: _____ Secondary Insurance _____

Policy Holder Name and Date of Birth: _____

Primary Doctor: _____ Referring Doctor: _____

Preferred Pharmacy: _____

Patient's Relationship to Responsible Party: **If "Self", skip to signature section** ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other _____

Name: _____ SSN: _____ DOB: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

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

Driver's Lic #: _____ Employer: _____ Work #: _____

Please check the box next to each section below indicating you have read, understand, and agree to each section and sign below:

☐ The above-named patient is either a **minor under 19** or an incapacitated adult requiring diagnosis and treatment. As legal guardian, I consent to such diagnostic procedures and treatments as necessary in the judgement of the doctors at GSA and/or their assistants.

☐ **MEDICATION HISTORY AUTHORITY:** General Surgery Associates has implemented an Electronic Health Records (EHR) system through Athenahealth that will automatically import the last 13 months of your medication history. This information is downloaded from the Pharmacy Benefits Manager utilized by your health insurance company. By signing below, I hereby authorize General Surgery Associates to download my Medication History.

☐ **ACKNOWLEDGEMENT OF RECEIPT / NOTICE OF PRIVACY PRACTICES:** I understand that upon request, I may obtain a copy of the Notice of Privacy Practices of General Surgery Associates, LLC.

☐ **ASSIGNMENT OF BENEFITS:** I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for the recommended services performed that are not covered under the terms of my health plan. I authorize the physician to release any medical information required to process this claim. I authorize my provider's office to contact me to remind me of my appointments.

Responsible Party Signature: _____ **Date:** _____

If you would like to give GSA permission to release your medical information to **someone other than your primary care or referring provider** (such as spouse, family member, friend, etc.) please provide their information below:

Name	Phone Number	Relation

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PATIENT NAME: _____ **TODAY'S DATE:**____/____/_____

MEDICAL HISTORY:

Reason for today's visit: _____

Medical Conditions/Diagnoses: _____

_____

_____

Previous Surgical Procedures/Operations & Dates: _____

_____

_____

Have you had a colonoscopy? No / Yes. If yes, when was this performed? _____

Are you currently pregnant? No / Yes, # of weeks: _____

Current Medication/Dosages: _____

_____

Are you currently taking any blood thinners-prescription or over the counter? No / Yes, _____
Aspirin/Arixtra/Aleve/Ibuprofen/Warfarin/Coumadin/Plavix/Pradaxa/Mobic/Effient/Fish Oil

Allergies/Reaction: _____

Latex Sensitivity: No / Yes, reaction: _____

Significant Family Medical History: _____

_____

Has there been any patient or family history of: Anesthesia Problems? No / Yes, reaction: _____
Bleeding Problems? No / Yes, reaction: _____

SOCIAL HISTORY:

Tobacco Use No / Yes, Amount: _____
Alcohol Use No / Yes, Amount: _____
Illicit Drug Use No / Yes, Amount: _____

How tall are you? _____ How much do you weigh? _____

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REVIEW OF SYSTEMS

Patient Name: _____ Date: _____

PLEASE CIRCLE THE APPROPRIATE ANSWER TO THE FOLLOWING CONDITIONS THAT YOU MIGHT BE EXPERIENCING:

Y / N Fevers

Y / N Night Sweats

Y / N Weight Loss/Weight Gain

Y / N Vision Changes

Y / N Hearing Loss

Y / N Nose Bleeds

Y / N Sinus Problems

Y / N Sore Throat

Y / N Chest Pain

Y / N Heart Palpitations

Y / N Heart Murmur

Y / N Pacemaker/Defibrillator

Y / N Shortness of Breath

Y / N Cough

Y / N Sleep Apnea

Y / N Abdominal Pain

Y / N Nausea/Vomiting

Y / N Diarrhea

Y / N Constipation

Y / N Gastroesophageal Reflux Disease (GERD)

Y / N Incontinence

Y / N Blood in Urine

Y / N Muscle Aches

Y / N Muscle Weakness

Y / N Rheumatoid Arthritis

Y / N Gout

Y / N Swelling of the Hands or Feet

Y / N Abnormal Skin Lesions

Y / N Psoriasis

Y / N Jaundice

Y / N Seizures

Y / N Headaches/Migraines

Y / N Dizziness

Y / N Anxiety

Y / N Depression

Y / N Swollen Glands

Y / N Bruising