

**GENERAL SURGERY
NEW PATIENT
INFORMATION PROFILE**

MIDTOWN SURGICAL SPECIALISTS

SPECIALISTS IN GENERAL AND VASCULAR SURGERY

Have you ever been a patient in this office for any doctor? Yes____ No____

Patient's Full Name: _____
(please print) (First) (Middle) (Last) (name called)

Mailing Address: _____
(Street / apt #) (City) (State) (Zip)

(Date of Birth) (Age) (Sex) (Marital status)

(Area code) (Phone #) (Cell #) (Work #)

(email address)

(Social Security #) (employer) (employer phone # & ext.)

=====

(Spouse's name) (Spouse's employer & phone #)

(Spouse's Date of Birth) (Spouse's SS #)

=====
Please state reason for seeing doctor today: _____

Dr. that referred you here: _____ **Primary Care Physician:** _____

Emergency contact name: _____ Phone: _____

Relationship to patient: _____ 2nd ph # _____

Primary Insurance Co: _____ Insured: _____

Secondary Insurance Co: _____ Insured: _____

Payment Information: *You will receive statements for balances due which are payable upon receipt. We are happy to assist you with account issues. If your account becomes delinquent & is referred to a 3rd party for collections, you are responsible for all collection and/or attorney fees. Per your insurance contract all co-pays are due at the time of office visits. Thank you for giving us the opportunity to serve you. Please refer to our payment policy for further information.*

FAMILY HISTORY

Family History:	Family Relationship:
<input type="checkbox"/> Colon Cancer	
<input type="checkbox"/> Breast Cancer	
<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart Attack	
<input type="checkbox"/> Stroke	
<input type="checkbox"/> Aneurysms	

SOCIAL HISTORY

Occupation:	
Marital Status:	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered
Tobacco use:	<input type="checkbox"/> Never <input type="checkbox"/> Previously, but quit <input type="checkbox"/> Currently (list packs/day and # of years)
Alcohol:	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Moderate <input type="checkbox"/> Daily

REVIEW OF SYSTEMS

Check the boxes that apply to YOU.

Constitutional:	<input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss
Eyes:	<input type="checkbox"/> Double vision <input type="checkbox"/> Blurred vision
Cardiovascular:	<input type="checkbox"/> Heart attack or chest pain <input type="checkbox"/> Pain in legs with walking
ENT:	<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Sore throat
Respiratory:	<input type="checkbox"/> Excessive shortness of breath <input type="checkbox"/> Chronic/Persistent cough
Gastrointestinal:	<input type="checkbox"/> Recent blood in stool <input type="checkbox"/> Heart Burn
Genitourinary:	<input type="checkbox"/> Difficulty with urination <input type="checkbox"/> Incontinence
Musculoskeletal:	<input type="checkbox"/> Leg cramps <input type="checkbox"/> Joint pain
Skin/Breast:	<input type="checkbox"/> Breast mass <input type="checkbox"/> Nipple discharge
Neurological:	<input type="checkbox"/> Seizures <input type="checkbox"/> Stroke
Psychiatric:	<input type="checkbox"/> Depression <input type="checkbox"/> Bipolar Disorder
Endocrine:	<input type="checkbox"/> Hot/Cold episodes <input type="checkbox"/> History of thyroid disease
Hematology/Lymphatic	<input type="checkbox"/> Abnormal bleeding <input type="checkbox"/> History of blood clots
Allergy/Immunology:	<input type="checkbox"/> Problems with anesthesia <input type="checkbox"/> Latex or tape allergy

Please list any other symptoms you are having in this area:

The above is true and correct to the best of my knowledge. (Please sign below)

Signature _____ Date _____

PATIENT ACKNOWLEDGMENT FORM

Patient's Name: _____ SSN: _____ DOB: _____

I understand that the patient's health information is private and confidential. I understand that Midtown Surgical Specialists works very hard to protect patient's privacy and preserve confidentiality of the patient's personal health information.

I understand that Midtown Surgical Specialists., P.C. may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

Midtown Surgical Specialists, P.C. has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and contains a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses and communications; and receiving an accounting of disclosures as required by law.

Midtown Surgical Specialists., P.C. may update this Acknowledgment and "Notice of Privacy Practices". If I ask, Midtown Surgical Specialists., P.C. will provide me with the most current "Notice of Privacy Practices".

Midtown Surgical Specialists., P.C. has established procedures which help them meet their obligations to patients. These procedures may include signature requirements, written acknowledgments/authorizations; reasonable time frames for requests, charges for copies and non-routine information needs; etc. I will assist Midtown Surgical Specialists., P.C. by following these procedures if I exercise any rights described in the "Notice of Privacy Practices".

I have received a copy of Midtown Surgical Specialists., PC's "Notice of Privacy Practices".

Signature: _____ Date: _____

Relationship to patient if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

With this consent, Midtown Surgical Specialists., P.C. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, and operations such as appointment reminders, insurance items and calls pertaining to my clinical care, including tests results, notification regarding surgery among others. This would apply to mailed information and e-mail also. I further authorize Midtown Surgical Specialists., P.C. to release my protected health information to my family members both verbally and written, and to mail prescription, disability forms, etc. to me or my family members as needed.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Signature: _____ Date: _____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc)

Printed name of Patient and/or Personal Representative: _____

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Patient Acknowledgment of Payment Policy

1. Payment of insurance co-payment prior to routine scheduled office visits is expected. This is required by your insurance company contract. If co-payment cannot be made at the time of service your appointment will be rescheduled to the next available time.
2. We will bill your insurance company for services rendered. Once insurance payment has been made and credited to your account, you will then receive a statement for any outstanding portion of the account (deductibles). We appreciate payment in full within 10 days. If payment cannot be made in full within 30 days of the first statement then we would appreciate you making arrangements with our billing office to set up a payment plan. A payment plan may be established with the office through use of:
 - a. Payment with a credit card
 - b. Extension of a line of credit through a medical services credit company
 - c. Establishing a monthly payment contract with our office
3. Statements will be mailed to you monthly for outstanding balances. If the account is not paid in full or no payment has been received by the fourth statement then the account balance may be forwarded for collections in accordance with laws established by the State of Georgia.
4. Prior to elective surgery we will confirm benefits and balances on deductibles with your insurance company. For your convenience, this will allow us to determine your portion of the bill prior to the procedure. We appreciate payment of this balance prior to the procedure, or establishing a payment plan prior to the procedure in order to avoid billing afterwards.
5. **Questions or concerns regarding your bills should be addressed directly with the billing staff and not your physician.**
6. We take pride in our relationship with you and appreciate you giving us the unique opportunity to care for you and your family. We understand that medical care can be costly. We are willing to work with you in any way possible to minimize the financial stress associated with having surgery and being ill. However, we can only do this if you communicate your concerns with our billing office and allow us to assist you in this matter.

Patient Signature

Date