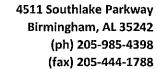
URGERY DATE:	1.100 (100 100 100 100 100 100 100 100 100					SURGERY CENTER
		SURGEON:	HEIGHT:	HEIGHT: WEIGHT: SEX: M F		
DATE OF BIRTH:/	/	PROCEDURE:	BEST CONTACT	Γ# F(OR T	HE DAY BEFORE SURGERY:
\GE:						
AVE YOU OR ANYONE IN	I YOUR FAMILY E\	/ER HAD PROBLEM	S WITH ANESTHESIA? IF SO, P	LEAS	E GI	VE DETAILS.
ALLERGIC TO LATEX?	ALLERGIC TO	BETADINE?				
YES or NO	YES or	1				
ALLERGIES	TYPE OF RI	EACTION				
71222110120			DO YOU HAVE	Υ	N	COMMENTS
			VISION PROBLEMS			
			HEARING PROBLEMS			
			DO YOU SMOKE?			PACKS/DAY:
			ASTHMA			
			DIFFICULTY BREATHING	ļ	ļ	
MEDICATION	DOSE	FREQUENCY	SNORE WHEN SLEEPING			
			SLEEP APNEA	<u> </u>		CPAP? YES or NO
			HEART DISEASE			
			VASCULAR DISEASE			
			HIGH BLOOD PRESSURE			
			BLEEDING PROBLEMS		ļ	
			KIDNEY DISEASE			
			HEPATITIS			
			JAUNDICE			
			HIV (AIDS)			
			REFLUX / HEART BURN			
			HIATAL HERNIA			HOW MUCH PER DAY?
			DRINK ALCOHOL?			HOW MUCH PER DAY?
			STROKE			
lave you used Aspirin, A			BACK/NECK PROBLEMS			
oody Powders, Excedring		- 1	ARTHRITIS			
ontaining medication or			PHYSICAL DISABILITY			
in the last 2-3 days? If	r so, wnich ones a	ina wnen?	DIABETES			
		<u> </u>	THYROID PROBLEMS			
			PREGNANT			
			MENTAL DISABILITY			
			MENTAL ILLNESS			
PREVIOUS SURC	GERY	DATE				
						NAME & OFFICE #
	-		PRIMARY CARE DOCTO	OR		-
		*****	CARDIOLOGIST			
			PULMONOLOGIST			
URSES COMMENTS :		BP:	/		LABS	S DRAWN :
· · · · · ·				K+		□ нст
				PT/II	NID	□

EKG:

RN SIGNATURE:_

RN SIGNATURE:





PATIENT INFORMATION

NAME:					
LAST NAME	FIRST NAI			MIDDLE INI	
DATE OF BIRTH://	AGE:	SSN :		_ SEX	:
ADDRESS :					
STREET		CITY	STATI	[ZIP CODE
MAIL ADDRESS :					
IOME PHONE :	CELL PHONE :		WORK PHONE	:	
MARITIAL STATUS :	EMPLOYER :			****	
	RESPONSIBLE BILLING				
(IF OTH	ER THAN SELF OR PATIEN	T IS 17 YEARS OF	AGE OR YOUNGE	ER)	
NAME :			DATE OF BIR	RTH:/_	/
LAST NAME	FIRST NAME MIDDLE II				
SN:	_ RELATIONSHIP TO PA	ATIENT:			
DDRESS :					
STREET		CITY	STATI	E	ZIP CODE
MPLOYER NAME / ADDRESS :		EET	CITY	STATE	ZIP CODE
	MEDICAF	RE PATIENTS	******		
RETIREMENT DATE :/	/	ARE YOU	A VETERAN? YES	/ NO	
DID THE VA REFER YOU? YES / N	0	HAVE YO	J SUFFERED FRO	M BLACK LU	JNG? YES / NO
ARE YOU ENTITLED TO MEDICA		OF ENDSTAGE K	DNEY DISEASE?	YES / NO	
	OTHER IN	FORMATION			
S THIS INJURY THE RESULT OF AN	ACCIDENT/INCIDENT? VES	/NO IEVES C	AR? VES / NO	WORK	YES / NO
	-				•
OATE OF INJURY ://	LOCATION / ADDR	RESS:			
DESCRIPTION OF ACCIDENT :					
	****				_
SIGNATURE :			D	ATE:	

Patient's Communication Preferences Regarding their PHI

Telepi	none Commur	ication Preferences			
Home	#				
Work #	#			Place Patient Identification	
Mobile	#				
Other					
E-Mai	l Communicat	ion Preferences			
Email	Address		· · ·		
methor Outpai using a answe If an ei notifica I recog improp informa messa not rec care in	ds of commu tient Surgery C a pre-recorded, ring device. mail address h ation regarding prize that text r perly while in st ation. If you w ges you also a quired to autho any way.	nication provided to exenter or one of its legal a fartificial voice message as been provided, Medplomy care, our services, onessaging is not a comporage or intercepted duriould like us to contact yogree to promptly update	etely secure means of communication ng transmission. The text messages you by text message please sign this con Medplex Outpatient Surgery Center wh aging and a decision not to sign this po	information above I agree that Medple provided to send me a text notification grant service or leave a voice message or fits legal agents may contact me with because these messages can be accourreceive may contain your personal sent below. If you consent to receiving the pour mobile phone number changes	ex on, call n an an email essed g text es. You are
May w	e send mail to		no, please provide an alternate mail		
		ormation? (Check all ti		your oute, internet the talk main	about .
		Name:	<u>Tele</u> ;	<u>phone</u>	
	Spouse				
	Caretaker			0.100.00 (URA)	
	Child			* 10 * 10 * 10 * 10 * 10 * 10 * 10 * 10	
	Parent				
	Other				
inform	ation.	_	oportunity to request restrictions on		
l ackni inform		have been given the o	oportunity to request alternative mea	ns of communication of my protect	ted health
Patien	t or Personal	Representative Signatu	re Dat	te	
Printe	d Name		Rel	ationship to Patient	

Medicare Secondary Payer Questionnaire (Short Form)

1. Are	you receiving benefits	s from any of the following programs?
	Black Lung Research Grant Veteran Affairs	NoYes NoYes NoYes
2. Was	the illness/injury due	to a work related accident/condition?
	No	Yes
	Date of injury/illness:	
3. Was	illness/injury due to a	non-work related accident?
	No	Yes
	Date of accident:	
	What type of accident Automobile Non-automobile	caused the illness/injury?
4. Are y	ou entitled to Medicar	e based on:
	Age Disability End Stage Rena	ıl Disease
5. Are y	ou currently employed	! ?
	No	Yes
6. Is yo	ur spouse currently en	nployed?
	No	Yes
	ou have group health ր 's, current employmen	olan (GHP) coverage based on your own, or a t?
	No	Yes
8. Does	the employer that spo	nsors your GHP employ 20 or more employees?
	No	Yes
		in a skilled nursing facility such as a nursing home? .ERT: If yes, bill SNF not Medicare)
	No	Yes
l confir	m that the above infor	nation is correct.
Patient	Signature:	
Please	Print Name:	