TODAY'S DATE: _____
SURGERY DATE: _____

PRE-EVALUATION CHECKLIST

MEDPLEX OUTPATIENT
SURGERY CENTER

NAME :	SURGEON:	HEIGHT : WEIGHT: SEX: M F
DATE OF BIRTH: ___ /___ /____ AGE:	PROCEDURE :	BEST CONTACT # FOR THE DAY BEFORE SURGERY:
HAVE YOU OR ANYONE IN YOUR FAMILY EVER HAD PROBLEMS WITH ANESTHESIA? IF SO, PLEASE GIVE DETAILS.		

ALLERGIC TO **LATEX**? YES or NO	ALLERGIC TO **BETADINE**? YES or NO
ALLERGIES	**TYPE OF REACTION**

MEDICATION	DOSE	FREQUENCY

Have you used Aspirin, Advil, Motrin, Ibuprofen, Aleve, Goody Powders, Excedrine, Stanback, or any other aspirin containing medication or anti-inflammatory medication in the last 2-3 days? If so, which ones and when?

_____
_____
_____

PREVIOUS SURGERY	DATE

DO YOU HAVE...	Y	N	COMMENTS
VISION PROBLEMS			
HEARING PROBLEMS			
DO YOU SMOKE?			PACKS/DAY :
ASTHMA			
DIFFICULTY BREATHING			
SNORE WHEN SLEEPING			
SLEEP APNEA			CPAP? YES or NO
HEART DISEASE			
VASCULAR DISEASE			
HIGH BLOOD PRESSURE			
BLEEDING PROBLEMS			
KIDNEY DISEASE			
HEPATITIS			
JAUNDICE			
HIV (AIDS)			
REFLUX / HEART BURN			
HIATAL HERNIA			
DRINK ALCOHOL?			HOW MUCH PER DAY?
STROKE			
BACK/NECK PROBLEMS			
ARTHRITIS			
PHYSICAL DISABILITY			
DIABETES			
THYROID PROBLEMS			
PREGNANT			
MENTAL DISABILITY			
MENTAL ILLNESS			

	NAME & OFFICE #
PRIMARY CARE DOCTOR	
CARDIOLOGIST	
PULMONOLOGIST	

NURSES COMMENTS : _____
_____
_____
RN SIGNATURE : _____

BP : ____ / ___
O2 SAT : _____
HR : _____
EKG : _____

LABS DRAWN :
☐ K+ ☐ HCT
☐ PT/INR ☐ _____

RN SIGNATURE : _____

MEDPLEX
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Birmingham, AL 35242
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(fax) 205-444-1788

PATIENT INFORMATION

NAME : _____
LAST NAME FIRST NAME MIDDLE INITIAL

DATE OF BIRTH : ___ / ____ / _____ **AGE :** _____ **SSN :** ____ - ____ - _____ **SEX :** _____

ADDRESS : _____
STREET CITY STATE ZIP CODE

EMAIL ADDRESS : _____

HOME PHONE : _____ **CELL PHONE :** _____ **WORK PHONE :** _____

MARITIAL STATUS : _____ **EMPLOYER :** _____

RESPONSIBLE BILLING PARTY / POLICY HOLDER

(IF OTHER THAN SELF OR PATIENT IS 17 YEARS OF AGE OR YOUNGER)

NAME : _____ **DATE OF BIRTH :** ___ / ____ / _____
LAST NAME FIRST NAME MIDDLE INITIAL

SSN : _____ **RELATIONSHIP TO PATIENT:** _____

ADDRESS : _____
STREET CITY STATE ZIP CODE

EMPLOYER NAME / ADDRESS : _____
NAME STREET CITY STATE ZIP CODE

MEDICARE PATIENTS

RETIREMENT DATE : ____ /____ /_____ **ARE YOU A VETERAN?** YES / NO

DID THE VA REFER YOU? YES / NO **HAVE YOU SUFFERED FROM BLACK LUNG?** YES / NO

ARE YOU ENTITLED TO MEDICARE SOLELY ON THE BASIS OF ENDSTAGE KIDNEY DISEASE? YES / NO

OTHER INFORMATION

IS THIS INJURY THE RESULT OF AN ACCIDENT/INCIDENT? YES / NO **IF YES... CAR?** YES / NO **WORK?** YES / NO

DATE OF INJURY : ____ / ____ / _____ **LOCATION / ADDRESS :** _____

DESCRIPTION OF ACCIDENT : _____

SIGNATURE : _____ **DATE :** _____

Patient's Communication Preferences Regarding their PHI

Telephone Communication Preferences

Home # _____

Work # _____

Mobile # _____

Other _____

Place Patient Identification

E-Mail Communication Preferences

Email Address_____

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that Medplex Outpatient Surgery Center or one of its legal agents may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service or leave a voice message on an answering device.
If an email address has been provided, Medplex Outpatient Surgery Center or one of its legal agents may contact me with an email notification regarding my care, our services, or my financial obligation.

I recognize that text messaging is not a completely secure means of communication because these messages can be accessed improperly while in storage or intercepted during transmission. The text messages you receive may contain your personal information. If you would like us to contact you by text message please sign this consent below. If you consent to receiving text messages you also agree to promptly update Medplex Outpatient Surgery Center when your mobile phone number changes. You are not required to authorize the use of text messaging and a decision not to sign this portion of the authorization will not affect your health care in any way.

_____

Patient's Signature for consent to text message.

Mail Communication Preferences

May we send mail to your home address? **(If no, please provide an alternate mailing address below.)**

_____

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information? (Check all that apply)

	Name:	Telephone
☐ Spouse	_____	_____
☐ Caretaker	_____	_____
☐ Child	_____	_____
☐ Parent	_____	_____
☐ Other	_____	_____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

_____ _____

Patient or Personal Representative Signature **Date**

_____ _____

Printed Name **Relationship to Patient**

Medicare Secondary Payer Questionnaire
(Short Form)

1. Are you receiving benefits from any of the following programs?

Black Lung	____No____Yes
Research Grant	____No____Yes
Veteran Affairs	____No____Yes

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 caused the illness/injury?
_____ Automobile
_____ Non-automobile

4. Are you entitled to Medicare based on:

_____ Age
_____ Disability
_____ End Stage Renal Disease

5. Are you currently employed?

_____ No _____ Yes

6. Is your spouse currently employed?

_____ No _____ Yes

7. Do you have group health plan (GHP) coverage based on your own, or a spouse's, current employment?

_____ No _____ Yes

8. Does the employer that sponsors your GHP employ 20 or more employees?

_____ No _____ Yes

9. Are you currently a patient in a skilled nursing facility such as a nursing home? (Long form not required. ALERT: If yes, bill SNF not Medicare)

_____No _____ Yes

I confirm that the above information is correct.

Patient Signature:_____

Please Print Name:_____