

**ONLY use these Forms if you CANNOT complete the forms online at  
www.sspaonline.com**

**SURGICAL SPECIALISTS PA - PATIENT INFORMATION**

(Please Print - Use Black Ink Only)

Date \_\_\_\_\_ Referring Doctor \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

LATEX Allergy  LATEX Sensitivity Explain Reaction: \_\_\_\_\_

Preferred Pharmacy/Address-Intersection/Phone Number \_\_\_\_\_

Patient's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ E-mail \_\_\_\_\_

(This will ONLY be used for Medical Communications from this Practice  
and our secure Patient Portal)

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Birth date \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

Sex  M  F Marital Status  Single  Married  Divorced  Widowed  Separated

Primary Language \_\_\_\_\_ Race \_\_\_\_\_ Ethnicity: Hispanic/Latino, Non-Hispanic, Declined  
(Please Circle Selection)

Patient's Employer \_\_\_\_\_ Business Phone # \_\_\_\_\_

Spouse/Parent's Name \_\_\_\_\_

Social Security # \_\_\_\_\_ Birth date \_\_\_\_\_

Spouse/Parent's Employer \_\_\_\_\_ Business Phone# \_\_\_\_\_

In case of emergency, whom may we contact? (Someone who is NOT living with you.)

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_  
(Initials) I have received a copy of Surgical Specialists, PA "Credit Policy". I have read and agree to this policy.

**Insurance**

In order for your insurance company to be billed, we MUST have copies of your cards on file. Without copies, the bill will be your responsibility.

PRIMARY Insurance Co. \_\_\_\_\_ Policy Holder \_\_\_\_\_

SECONDARY Insurance Co. \_\_\_\_\_ Policy Holder \_\_\_\_\_

Other Insurance Co. \_\_\_\_\_ Policy Holder \_\_\_\_\_

**Assignment and Release**

I hereby authorize Surgical Specialists, P. A. to release information requested by my insurance company or Worker's Compensation carrier, to any hospital or physician this office may refer me to. I hereby authorize assignment and payment directly to Surgical Specialists, P. A. major medical benefits due me.

X

Signature of Responsible Party

Relationship to Patient

Date

Account No. \_\_\_\_\_

Dr. Smith

Dr. Gaston

Dr. Neff

**Permission to Disclose Information to Those Involved in My Care**

I hereby allow **Surgical Specialists P.A.**, to disclose the following Protected Health Information to the below listed People, in the following Forms of communication:

**(PLEASE CHECK ALL BOXES THAT APPLY)**

<p>Protected Health Information (What information can we give out?)</p> <input type="checkbox"/> All <input type="checkbox"/> Appointment times and dates <input type="checkbox"/> Tests that have been received <input type="checkbox"/> Test results <input type="checkbox"/> Other health information	<p>People (Name and phone number) (Who can we give information to?)</p> <input type="checkbox"/> Self Only <p><b>OR</b></p> <p>(Please provide first and last names)</p> <input type="checkbox"/> Spouse _____ <input type="checkbox"/> Family friend _____ <input type="checkbox"/> Child _____ <input type="checkbox"/> Other _____	<p>Forms of Communication (How may we contact you?)</p> <input type="checkbox"/> Home telephone _____ <input type="checkbox"/> Work telephone _____ <input type="checkbox"/> Home voice messaging system <input type="checkbox"/> Work voice messaging system <input type="checkbox"/> Cellular phone _____ <input type="checkbox"/> E-mail _____ <input type="checkbox"/> U.S. Mail _____ <input type="checkbox"/> Other _____ _____
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**RECEIPT OF NOTICE OF PRIVACY PRACTICES  
WRITTEN ACKNOWLEDGMENT FORM**

I, \_\_\_\_\_, have received a copy of **Surgical Specialists, PA** "Notice of Privacy Practices".

**X** \_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

**(For Office Use Only)**

**Documentation of Good Faith Efforts**

The patient presented to **Surgical Specialists, P.A.** on \_\_\_\_\_ and was provided with a copy of this office's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgment was not obtained because:

- Patient refused to sign.
- Patient was unable to sign or initial because:  
\_\_\_\_\_
- The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- Other reason (describe below):  
\_\_\_\_\_

Signature of Employee Completing Form: \_\_\_\_\_

## Surgical Specialists PA – Current Symptoms Review

Acct. Number: \_\_\_\_\_

### Current Symptoms Review (Check all that have occurred **Recently**, explain if needed)

<b>Constitutional</b>	<input type="checkbox"/> Fatigue <input type="checkbox"/> Fever	<input type="checkbox"/> Chills <input type="checkbox"/> Body aches	<input type="checkbox"/> Night sweats <input type="checkbox"/> <i>No Current Problems</i>
<b>HEENT</b>	<input type="checkbox"/> Headaches <input type="checkbox"/> Vertigo (Dizziness) <input type="checkbox"/> Sore throat	<input type="checkbox"/> Dental Problems <input type="checkbox"/> Neck pain	<input type="checkbox"/> Thyroid mass <input type="checkbox"/> Neck Tenderness <input type="checkbox"/> <i>No Current Problems</i>
<b>Breast</b>	<input type="checkbox"/> Lumps <input type="checkbox"/> Tenderness	<input type="checkbox"/> Swelling	<input type="checkbox"/> Nipple Discharge <input type="checkbox"/> <i>No Current Problems</i>
<b>Cardiovascular</b>	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Claudication (Leg cramps with exercise) <input type="checkbox"/> Syncope (Passing out)	<input type="checkbox"/> Orthostatic symptoms (Dizzy when getting up too fast) <input type="checkbox"/> Orthopnea (Short of breath when lying down) <input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Dyspnea on Exertion (Shortness of breath) <input type="checkbox"/> Cyanosis (Discoloration of feet, hands, lips) <input type="checkbox"/> <i>No Current Problems</i>
<b>Respiratory</b>	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing	<input type="checkbox"/> Cough	<input type="checkbox"/> Hoarseness <input type="checkbox"/> <i>No Current Problems</i>
<b>Gastrointestinal</b>	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation	<input type="checkbox"/> Blood in stools <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Reflux	<input type="checkbox"/> Heartburn <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> <i>No Current Problems</i>
<b>Genitourinary/ Gynecological</b>	<input type="checkbox"/> Urgency <input type="checkbox"/> Frequency	<input type="checkbox"/> Urinary burning/pain <input type="checkbox"/> Hematuria (Blood in urine)	<input type="checkbox"/> Incontinence <input type="checkbox"/> Possible pregnancy <input type="checkbox"/> <i>No Current Problems</i>
<b>Integument</b>	<input type="checkbox"/> Rash/Itching <input type="checkbox"/> New skin lesions	<input type="checkbox"/> Skin dryness <input type="checkbox"/> Nail changes	<input type="checkbox"/> Changes to existing skin lesions and moles <input type="checkbox"/> Pigmentation changes <input type="checkbox"/> <i>No Current Problems</i>
<b>Neurologic</b>	<input type="checkbox"/> Speech difficulties <input type="checkbox"/> Tremors	<input type="checkbox"/> Memory difficulties	<input type="checkbox"/> Loss of balance <input type="checkbox"/> <i>No Current Problems</i>
<b>Musculoskeletal</b>	<input type="checkbox"/> Joint pain <input type="checkbox"/> Joint swelling	<input type="checkbox"/> Muscle pain <input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Muscle cramps <input type="checkbox"/> Back pain <input type="checkbox"/> <i>No Current Problems</i>
<b>Endocrine</b>	<input type="checkbox"/> Weight loss <input type="checkbox"/> Loss of hair	<input type="checkbox"/> Weight gain <input type="checkbox"/> Cold intolerance	<input type="checkbox"/> Heat intolerance <input type="checkbox"/> <i>No Current Problems</i>
<b>Psychiatric</b>	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> <i>No Current Problems</i>
<b>Heme-Lymphatics</b>	<input type="checkbox"/> Lymph node Enlargement or tenderness	<input type="checkbox"/> Easy bleeding	<input type="checkbox"/> Easy bruising <input type="checkbox"/> <i>No Current Problems</i>
<b>Allergic-Immunologic</b>	<input type="checkbox"/> Allergy symptoms	<input type="checkbox"/> Allergic dermatitis	<input type="checkbox"/> <i>No Current Problems</i>

Thank you for taking the time to fill out this questionnaire. It helps us to find out details about each new patient's problem or an established patient's new problem. The information you give is vital to providing you with the optimum and efficient care. Please ask for any explanation or assistance in completing this questionnaire.

**Today's Date:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Signature of the Patient** (or the person who filled out this form) \_\_\_\_\_

## Surgical Specialists PA – Patient Medical History Form

Today's Date: \_\_\_\_\_

Acct. Number: \_\_\_\_\_

Patient Name: **X** \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Signature of the Patient (or the person who filled out this form) **X** \_\_\_\_\_

**PLEASE use black ink. Fill in or check the appropriate response. Additional questions are on next page.**

1. What is the reason for your visit? \_\_\_\_\_

2. Is your problem due to an accident? (check all that apply): Yes    No    Due to: Work.

**3. Past Medical History (Check all boxes that apply):**

<b>Head, eyes, ears, nose and throat (HEENT)</b> <input type="checkbox"/> NONE	<input type="checkbox"/> Glaucoma <input type="checkbox"/> Hearing Aid	<input type="checkbox"/> Glasses <input type="checkbox"/> Dentures	<input type="checkbox"/> Blindness
List others: _____			
<b>Heart and Blood Pressure (Cardiovascular)</b> <input type="checkbox"/> NONE	<input type="checkbox"/> Abdominal aneurysm <input type="checkbox"/> Coronary artery disease <input type="checkbox"/> Heart attack <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Mitral valve prolapse	<input type="checkbox"/> Valvular disorders <input type="checkbox"/> Deep venous thrombosis (DVT) <input type="checkbox"/> Peripheral vascular occlusive disease <input type="checkbox"/> Phlebitis <input type="checkbox"/> History of Blood Clots	<input type="checkbox"/> Thoracic aortic aneurysm <input type="checkbox"/> Stroke (CVA) <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Heart murmur <input type="checkbox"/> Congestive heart failure
List others: _____			
<b>Lungs (Pulmonary)</b> <input type="checkbox"/> NONE	<input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Sleep Apnea --- If yes --	<input type="checkbox"/> COPD (Chronic obstructive pulmonary disease) Do you use CPAP? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Chronic bronchitis <input type="checkbox"/> Tuberculosis
List others: _____			
<b>Thyroid, Pancreas (Endocrine)</b> <input type="checkbox"/> NONE	<input type="checkbox"/> Hyperthyroidism (high) <input type="checkbox"/> Hypothyroidism (low)	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hyperparathyroidism
List others: _____			
<b>Stomach, Bowels (Gastrointestinal)</b> <input type="checkbox"/> NONE	<input type="checkbox"/> Colitis <input type="checkbox"/> Ulcerative colitis <input type="checkbox"/> Barrett's <input type="checkbox"/> Liver disorder	<input type="checkbox"/> Diverticulosis <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Irritable bowel syndrome <input type="checkbox"/> Fecal incontinence	<input type="checkbox"/> Diverticulitis <input type="checkbox"/> Gastroesophageal reflux disease (GERD) <input type="checkbox"/> Ulcers <input type="checkbox"/> Cirrhosis
List others: _____			
<b>Kidneys, Bladder, Genitalia (Genitourinary)</b> <input type="checkbox"/> NONE	<input type="checkbox"/> Renal failure <input type="checkbox"/> Kidney stones	<input type="checkbox"/> Enlarged Prostate <input type="checkbox"/> Dialysis	<input type="checkbox"/> Urinary incontinence
List others: _____			
<b>Blood Disorders (Immune and Hematological)</b> <input type="checkbox"/> NONE	<input type="checkbox"/> Hepatitis Type: _____	<input type="checkbox"/> Clotting disorder <input type="checkbox"/> Hemophilia	<input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Anemia
List others: _____			

<b>Cancer (Neoplastic)</b> <input type="checkbox"/> NONE	<input type="checkbox"/> Lung <input type="checkbox"/> Breast <input type="checkbox"/> Prostate <input type="checkbox"/> Kidney <input type="checkbox"/> Cervical	<input type="checkbox"/> Thyroid <input type="checkbox"/> Uterine <input type="checkbox"/> Bladder <input type="checkbox"/> Melanoma <input type="checkbox"/> Ovarian	<input type="checkbox"/> Skin <input type="checkbox"/> Bone <input type="checkbox"/> Lymphoma <input type="checkbox"/> Colon
	List others:		
<b>Neurological</b> <input type="checkbox"/> NONE	<input type="checkbox"/> Parkinson's <input type="checkbox"/> Seizures <input type="checkbox"/> Memory difficulties	<input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Dementia	<input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Alzheimer's
	List others:		
<b>Psychiatric</b> <input type="checkbox"/> NONE	<input type="checkbox"/> Anxiety disorder <input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Depression	<input type="checkbox"/> Bipolar
	List others:		
<b>Women's Health</b>	<input type="checkbox"/> Menopausal <input type="checkbox"/> Your age at birth of first live child:	Date – Last mammogram:	Date – Last pap smear & pelvic:

Explain above in detail if needed: \_\_\_\_\_  
 \_\_\_\_\_

4. Past Surgical History (Please include any EGD's, colonoscopies, and breast biopsies)			
Anesthesia	Have you had any problems with anesthesia: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Explain:			
Type of Surgery	When	Where	Surgeon
<input type="checkbox"/> No Past Surgical History			

5. Current Medications – Include OTC, Herbs, and Supplements	Dosage (mg)	Frequency (Taken __ times per day) 1, 2, 3....	Form (Pill, Liquid, IM, IV)	Prescribing Physician
<input type="checkbox"/> No Current Medications				

Patient Name: **X** \_\_\_\_\_

Date of Birth \_\_\_\_\_

<b>6. Allergies (Drugs, food, environmental)</b>	<b>Reactions</b>
<input type="checkbox"/> No Known Allergies	
<input type="checkbox"/> LATEX Allergy <input type="checkbox"/> LATEX Sensitivity	

<b>7. Reproductive History</b>	Date – Last menstrual period started:	Age at time of 1 <sup>st</sup> Period:
	Number of pregnancies:	Number of living children:

<b>8. Family History</b> Please indicate below significant medical problems of family members by checking the appropriate column. <input type="checkbox"/> Adopted – Family History Unknown <input type="checkbox"/> No Family History of Problems listed Below	<b>Mother</b>	<b>Father</b>	<b>Brother</b>	<b>Sister</b>	<b>Grandmother (maternal)</b>	<b>Grandmother (paternal)</b>	<b>Grandfather (maternal)</b>	<b>Grandfather (paternal)</b>
Heart Disease								
High Blood Pressure								
Diabetes								

<b>Cancer – Please list family member and age at cancer diagnosis (if applicable)</b>		
Breast:	Colon/Rectal:	Other (please list):
Ovarian:	Pancreatic:	
Uterine:	Melanoma:	

<b>9. Social History</b>			
<b>What is your current occupation?</b>			
Work Status	<input type="checkbox"/> Working <input type="checkbox"/> Not working <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Retired		
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed		
Tobacco Use/Smoking	<input type="checkbox"/> Never <input type="checkbox"/> Former <input type="checkbox"/> Current	Packs per day: Type of tobacco:	Number of years: Age when Stopped:
Alcohol Use	<input type="checkbox"/> No <input type="checkbox"/> Yes	Drinks per week:	What type of alcohol?
Oral Intake of Fluids	Caffeine: How much per day? Water: How much per day?		

Patient Name: **X** \_\_\_\_\_

Date of Birth: \_\_\_\_\_