Surgical Specialists, P.A.
4013 N. Ridge Rd. #210 Wichita, Kansas 67205
(316) 945-7309 Fax (316) 945-9131

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 _____

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 _____

If Insurance Policy Holder:

Birth Date _____ Social Security # (*If Tricare*) _____

Spouse/Parent's Employer _____ Business Phone# _____

Emergency Contact _____ Relationship _____

Emergency Contact Phone _____

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

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. Gaston Dr. Misasi Dr. Walters

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)

Protected Health Information
(What information can we give out?)

- ☐ All
- ☐ Appointment times and dates
- ☐ Tests that have been received
- ☐ Test results
- ☐ Other health information

People (Name and phone number)
(Who can we give information to?)

- ☐ Self Only

OR

(Please provide first and last names)

- ☐ Spouse Name/Phone Number:_____
- ☐ Family friend Name/Phone Number:_____
- ☐ Child Name/Phone Number:_____
- ☐ Other Name/Phone Number:_____

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: _____

4013 N. Ridge Road, Suite 210
Wichita, Kansas 67205
316-945-7309

Surgical Specialists PA – Current Symptoms Review

Acct. Number: _____

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

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

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):

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

Cancer (Neoplastic) ☐*NONE*	☐Lung ☐Breast ☐Prostate ☐Kidney ☐Cervical	☐Thyroid ☐Uterine ☐Bladder ☐Melanoma ☐Ovarian	☐Skin ☐Bone ☐Lymphoma ☐Colon
	List others:		
Neurological ☐*NONE*	☐Parkinson's ☐Seizures ☐Memory difficulties	☐Multiple sclerosis ☐Dementia	☐Fibromyalgia ☐Alzheimer's
	List others:		
Psychiatric ☐*NONE*	☐Anxiety disorder ☐Schizophrenia	☐Depression ☐Mentally Challenged	☐ Bipolar ☐Autism
	List others:		
Women's Health	☐Menopausal Date – Last pap smear & pelvic: ☐Your age at birth of first live child:		

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**:** ☐**Yes** ☐No Explain:		
Type of Surgery	**When**	**Where**	**Surgeon**
☐ **No Past Surgical History**			

5. Current Medications –Include OTC, Herbs, and Supplements	**Dosage** (mg)	**Frequency** (Taken __ times per day) 1, 2, 3….	**Prescribing Physician**
☐ **No Current Medications**			

Patient Name: X_____ Date of Birth:_____

6. Allergies (Drugs, food, environmental)	Reactions
☐No Known Allergies	
☐LATEX Allergy ☐LATEX Sensitivity	

7. Reproductive History	Date – Last menstrual period started (M/D/YR):	Age at time of 1st Period:
	Number of pregnancies:	Number of living children:

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

Cancer – Please list family member and age at cancer diagnosis (if applicable). Include Parents, Siblings, Children, Grandparents, Uncles, Aunts and Cousins. Indicate "P" for paternal or "M" for maternal. Example: Breast: Grandmother/P

Breast:	Colon/Rectal:	Other (please list):
Ovarian:	Pancreatic:	
Uterine:	Melanoma:	

9. Social History			
What is your current occupation?			
Work Status	☐Working ☐Not working ☐Student ☐Disabled ☐Retired		
Marital Status	☐Single ☐Divorced ☐Married ☐Widowed		
Tobacco Use/Smoking	☐ Never ☐ Former ☐ Current	Packs per day: Type of Tobacco:	Number of years used: Age when Stopped?
Alcohol Use	☐No ☐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: _____

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Patient Name:_____ DOB_____

The following are preventative screenings and quality measures that are important to your health. Indicate the date you have received the following:

Colonoscopy screening: Date:_____	Pneumonia vaccination: Date:_____
A1C (diabetic) result: Date:_____	Mammogram: (women only) Date:_____
Influenza vaccination:(vaccine) Date:_____	Cervical cancer (women only) Date:_____
Tobacco user: ☐ Never ☐ Former ☐ Current	

Current Medical Providers (Please list below the physicians currently treating your conditions)	
Primary Care or Family Physician	_____
Referring	_____
Cardiologist	_____
Endocrinologist	_____
Pulmonologist	_____
Oncologist	_____
Previous Surgeons	_____
Gastroenterologist	