ROPER ST FRANCIS
Physician Partners

SURGICAL ASSOCIATES OF CHARLESTON

Patient Information

Referred By: _____

Last Name: _____ ☐ Mr. ☐Mrs. ☐ Miss ☐ Other _____ Sex: Male _____ Female _____

First Name: _____ Date of Birth: ____/____/____ Age _____ SSN: _____-_____-_____

Middle Name: _____ Preferred Name: _____ Primary Language: _____

Marital Status: ☐Married ☐Single ☐Separated ☐Divorced ☐Widowed Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino

Address: _____ City: _____ County_____ State: _____ Zip: _____

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or OPI ☐White

Student Status: ☐Full ☐Part ☐N/A School:_____ Employment: ☐Full ☐Part ☐N/A Employer: _____

Email Address: _____

Phone: Home ( ) _____ Work ( ) _____ Cell: ( ) _____

May we leave a voice message to remind you about appointments at your home or cell phone number? Yes _____ No _____

May we leave a voice message for normal test results at your home or cell phone number? Yes _____ No _____

(Pharmacy Name and Phone Number: _____

Emergency Contact Name _____

Relationship_____ Home Phone ( )_____ Work Phone ( )_____

Complete only if you want the Practice to contact you at an address/phone different than you gave above)

Other Address: _____City: _____ State:_____ Zip: _____ Other Phone ( ) _____

Guarantor/Responsible Person (if different from patient)

Last Name: _____ ☐ Mr. ☐Mrs. ☐ Miss ☐ Other _____ Sex: Male _____ Female _____

First Name: _____ Date of Birth: ____/____/____ Age _____ SSN: _____-_____-_____

Middle: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home ( ) _____ Work ( ) _____ Cell: ( ) _____

Guarantor Email Address: _____

Primary Insurance

Insurance Company: _____

Policyholder Name: _____

Member or Policyholder ID#: _____

Policy Holder Date of Birth:_____

Insurance Co. Phone Number: (_____)_____

Group #_____

Insurance Co. Address: _____

City:_____ State:_____ Zip:_____

Secondary Insurance

Insurance Company: _____

Policyholder Name: _____

Member or Policyholder ID#: _____

Policy Holder Date of Birth: _____

Insurance Co. Phone Number:(_____)_____

Group #_____

Insurance Co. Address: _____

City:_____ State:_____ Zip:_____

Ongoing Communication Regarding Your Healthcare

We may release/discuss your health information with the following people or organizations for the following dates of service, range of time, or event(s):

From (MM/DD/YY) _____ To (MM/DD/YY) _____

Name (Physician, family, etc)	Address	Phone/Fax	Relationship

A separate Authorization to Release Information form must be completed if the information being released is different for these people or organizations listed above.

Authorization, Assignment of Benefits, and Referral Medical Release

I allow this Practice to use and release my protected health information for treatment, payment and healthcare operations as allowed by HIPAA and as described in the Roper St. Francis Healthcare Notice of Information Practices. I have been provided a copy of the Roper St. Francis Healthcare Notice of Information Practices.

I allow the release of medical information including complete medical records, test results, and billing information to my insurance company and to other medical professionals and medical care institutions that I may be referred to for treatment.

I request the following restrictions on the use of my information: _____

_____

I allow payment made directly to Roper St. Francis Healthcare for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for paying all co-payments, co-insurance, deductibles and non-covered services. A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep this practice and my physician informed of changes to any of my contact information; a failure to do so may interfere with the ability to contact me concerning my healthcare.

Patient Signature: _____ Date ____/____/____

Guardian Signature: _____ Date ____/____/____

Office Use Only:

SURGICAL ASSOCIATES OF CHARLESTON, P.A.

PATIENT HEALTH HISTORY

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*:	**DOB:**	**Age:**

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Referring physician:	**Primary care physician:**

PERSONAL HEALTH HISTORY

Current Chief Complaint:

List any medical problems that other doctors have diagnosed

Operations	**Year**	**Hospital**

Other hospitalizations	**Year**	**Hospital**

List your prescribed and over-the-counter drugs or vitamins	**Strength**	**Frequency taken**

Allergies to medications	**Reactions you had**

TO COMPLETE TURN OVER

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	How many drinks per week?				
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – packs/day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	Significant Health Problems		AGE	Significant Health Problems
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Siblings	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandparents**		
	☐ M ☐ F				

REVIEW OF SYSTEMS / OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly expalin.

☐ Skin	☐ Chest / Heart	Recent changes in:
☐ Head	☐ Musculoskeletal	☐ Weight
☐ Eyes	☐ Intestinal / Bowel / GI	☐ Energy level
☐ Nose / Ears / Throat	☐ Bladder	☐ Neuro - Seizures, etc.
☐ Neck / Lymph	☐ Psych - Depression	☐ Other pain / discomfort:
☐ Lungs	☐ Circulation	

WOMEN ONLY

Age at onset of menstruation:	Date of last menstruation:		
Period every _____ days	Date of last pap and rectal exam:		
Heavy periods, irregularity, spotting, pain, or discharge?		☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____			
Are you pregnant or breastfeeding?		☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Caesarean?		☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?		☐ Yes	☐ No
Any blood in your urine?		☐ Yes	☐ No
Any history of taking hormone replacement pills?		☐ Yes	☐ No
Any family history of breast disease or breast cancer?		☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?		☐ Yes	☐ No

Patient Signature _____ **Date** _____

Reviewed and Confirmed by Physician _____ **Date** _____