

Name: _____

FAMILY HISTORY

Please check illnesses that have occurred in any of your blood relatives and indicate which relative:

Condition	Relatives
Stroke	
High Blood Pressure	
Heart Disease	
Bleeding Tendencies	
Urinary Tract Infection	
Cancer (<i>specify type</i>)	
Kidney Disease	
Kidney Stones	
Diabetes	
Mental Illness	
Alcoholism	
Other: _____	

PERSONAL MEDICAL HISTORY

Please check all illnesses or conditions which you have now or had in the past:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Elevated Cholesterol	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Heart Trouble, Type _____
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Depression	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Hepatitis A, B or C	<input type="checkbox"/> Bleeding Tendencies	<input type="checkbox"/> Stroke/TIA
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cancer, Type _____	<input type="checkbox"/> Obesity
<input type="checkbox"/> Nervous Disorder	<input type="checkbox"/> HIV	<input type="checkbox"/> Reflux (heartburn), Stomach Ulcer
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Thyroid problems, Type _____	<input type="checkbox"/> Sleep Apnea	

PRIOR SURGERIES

Please list all the surgeries you had done and when you had them:

Surgery	Year

Name: _____

REVIEW OF SYMPTOMS

<i>Do you now have or ever had the following:</i>			
Significant weight change	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Increase/Decrease by how many pounds	+ lbs____ - lbs____	Swelling of hands or feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any eye disease, injury, impaired sight	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breast lumps	<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weakness in arm or leg	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pain radiating down arm	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent or severe headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any trouble with nose, sinuses, mouth, and throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Varicose veins	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach trouble or ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning pain during urination	<input type="checkbox"/> Yes <input type="checkbox"/> No	Enlarged glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Trouble swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Constipation or diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of bladder control	<input type="checkbox"/> Yes <input type="checkbox"/> No	Enlarged thyroid or goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pain or tightness in the chest	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemorrhoids or rectal bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood in urine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in joints or gout	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coughing up blood	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting spells	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent Urination	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin irritation or rashes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Night Sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of consciousness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Trouble with erections	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression or anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No
Palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spells of dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Painful intercourse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hallucinations	<input type="checkbox"/> Yes <input type="checkbox"/> No

FEMALES ONLY

Date of last PAP: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify): _____
Last menstrual period: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify): _____
Date of last Mammogram: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (specify): _____
Number of pregnancies:	
Number of miscarriages:	
Birth control method:	
Periods are: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Painful <input type="checkbox"/> Cramps	

Name: _____

OFFICE POLICY AND FINANCIAL RESPONSIBILITY

Please read the following office policies. We would like for you to read and sign accordingly. Thank you for choosing Surgical Associates at Virginia Hospital Center.

It is your responsibility to be aware of your insurance policy. Please provide us with a current insurance card at the time of check-in. You will be asked at all subsequent visits if your insurance and/or demographic information has changed. If you fail to give our office your new insurance card, you may be responsible for the full office charge. You are required to pay any applicable co-pays or current balances at the time of check-in unless you have made prior arrangements with the Practice Administrator.

Surgical Associates at Virginia Hospital Center is not responsible if you fail to obtain the required authorization. If a referral is required for your insurance, you - the patient - are responsible to obtain the referral prior to your visit from your Primary Care Physician. If you do not have the required referral at the time of your appointment, payment will be due at the time of service. If there are any issues regarding your appointment, we can reschedule your appointment at your convenience.

If you are not able to keep your appointment, please provide 1 (one) business day notice. Failure to provide appropriate notice will result in a \$35 fee for the missed appointment. We understand that emergencies happen and will take into consideration before any chargers are applied to your account.

Surgical Associates at Virginia Hospital Center will make every attempt to ensure you are seen in a timely manner. However our surgeons are occasionally called to emergencies. This may delay your appointment or you may be asked to reschedule your appointment. We appreciate your patience and understanding.

I have read the above policy.

Patient Name

Signature of Patient (or Parent/Legal guardian)

Name of Parent/Legal Guardian (if applicable)

Date

Name: _____

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use and disclosure of my Protected Health Information (PHI) by Surgical Associates at Virginia Hospital Center for the purposes of diagnosing or providing treatment for me, obtaining payment for my health care bills or to conduct health care operations for the practice of Surgical Associates at Virginia Hospital Center. I understand that diagnosis or treatment of me by Surgical Associates at Virginia Hospital Center may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have a right to request a restriction as how my "PHI" is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Surgical Associates at Virginia Hospital Center is not required to agree to the restrictions that I may request. However, if Surgical Associates at Virginia Hospital Center agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that Surgical Associates at Virginia Hospital Center has taken action in reliance on this consent.

My "PHI" means health protection, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This "PHI" related to my past, present or future physical or mental health condition and identifies me or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Virginia Hospital Center Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my "PHI" that will occur in my treatment, payment of my bills or in the performance of healthcare operations of the practice. The Notice of Privacy Practices for the practice is also provided to the front desk. This Notice of Privacy Practices also describes my rights and the practice's duties with respect to my "PHI".

Surgical Associates at Virginia Hospital Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting one in the mail or by asking for one at the time of my next appointment.

Patient Name

Signature of Patient (or Parent/Legal guardian)

Name of Parent/Legal Guardian (if applicable)

Date