PATIENT INFORMATION

1. PATIENT'S NAME (LAST, FIRST, MI) _____
2. SOCIAL SECURITY_____ 3. BIRTHDATE _____4.SEX M / F 5. MARITAL STATUS _____
6. STREET ADDRESS _____APT#_____
CITY_____STATE_____ZIP_____COUNTY_____
7. EMAIL ADDRESS _____
8. HOME PHONE#_____9. CELL PHONE# _____
10. EMPLOYER NAME _____ PHONE# _____
ADDRESS _____CITY, ST, ZIP_____
11. SPOUSE NAME _____ 12. BIRTHDATE _____
13. SPOUSE EMPLOYER _____ 14. WORK PHONE _____
15. REASON FOR VISIT _____ 16. REFERRING PHYSICIAN_____
17. WHO DO WE NOTIFY IN CASE OF EMERGENCY? NAME_____
HOME _____ CELL_____WK_____
RELATIONSHIP TO PATIENT_____

INSURANCE INFORMATION (IF OTHER THAN PATIENT)

1. NAME OF INSURANCE COMPANY _____
2. POLICY HOLDER (FIRST & LAST NAME) _____
3. SOCIAL SECURITY# _____ 4.BIRTHDATE _____
5. HOME PHONE# _____6. WORK #_____ 7. CELL# _____
8. HOME ADDRESS (IF DIFFERENT FROM ABOVE) _____
_____
9. EMPLOYER ADDRESS _____
_____

PLEASE READ BEFORE SIGNING

** I ATTEST THAT ALL THE INFORMATION PROVIDED ABOVE IS CORRECT AND CURRENT. I UNDERSTAND THAT PROVIDING FALSE INFORMATION IS A CRIME.

** I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO SOUTHERN SURGICAL ASSOCIATES FOR ANY SERVICES RENDERED. I PERMIT A COPY, IN PLACE OF THE ORIGINAL, OF MY DATED SIGNATURE TO BE USED AS AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS NECESSARY TO PROCESS ANY CLAIM FOR PROFESSIONAL SERVICES RENDERED.

** I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED TO ME (THE PATIENT), INCLUDING THE BALANCE AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS.

** I UNDERSTAND THAT IF MY INSURANCE COMPANY HAS NOT PAID WITHIN 60 DAYS FROM DATE OF SERVICE I WILL BE BILLED.

** IF MY ACCOUNT IS TURNED OVER TO COLLECTIONS, I WILL BE RESPONSIBLE FOR ALL COSTS AND FEES ASSOCIATED WITH THE COLLECTION OF THIS ACCOUNT. **

PATIENT'S SIGNATURE _____DATE _____
GUARDIAN'S SIGNATURE_____DATE_____
(IF PATIENT IS UNDER 18)

PAST MEDICAL HISTORY

NAME_____ D.O.B_____

HEIGHT / WEIGHT_____PLACE OF BIRTH_____

PRESENT COMPLAINT _____

LIST PREVIOUS SURGERIES (YEAR & TYPE)

_____

_____

_____

LIST OTHER MEDICAL PROBLEMS (CANCER, DIABETES, HIGH BLOOD PRESSURE, ETC)

_____

_____

_____

LIST ALL PERSCRIBED AND OVER THE COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING INSULIN, BIRTH CONTROL, AND ETC.)

_____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATION? YES / NO IF YES, PLEASE LIST BELOW

_____

_____

_____

	(PLEASE CIRCLE)	
HAVE YOU TAKEN CORTISONE TYPE (STEROID) DRUGS?	YES	NO
HAVE YOU HAD A BLOOD TRANSFUSION?	YES	NO
DO YOU CURRENTLY USE TOBACCO?	YES	NO
HAVE YOU USED TOBACCO IN THE PAST?	YES	NO
DO YOU DRINK ALCOHOLIC BEVERAGES?	YES	NO
DO YOU DRINK COFFEE?	YES	NO

Gwinnett Medical Center
Lawrenceville • Duluth
The hospital Gwinnett deserves.

Patient Name: _____ Date of Surgery: _____

Surgeon: _____ ☐ **MAIN OR** ☐ **GDS OR**

Patient DOB: _____ Patient Phone #: _____

IMPACT (> 3 DAYS)

	Part One: Patients: Please answer the following questions:	YES	NO
1.	Do you have heart problems such as chest pain, heart failure, history of heart surgery, pacemaker or ICD, aortic aneurysm, or heart attack?		
2.	Are you on home oxygen? Have you had worsening shortness of breath in the past 2 months? Do you take steroid pills (like prednisone) daily for any reason?		
3.	Do you take insulin for diabetes?		
4.	Are you on dialysis? (hemo or peritoneal)		
5.	Have you had a stroke within the past 12 months? Or seizure in past 6 months?		
6.	Do you take prescription blood thinners?		
7.	Do you have to stop and rest when walking up a flight of steps?		
8.	Do you have liver disease or cirrhosis?		
9.	Do you have bleeding problems or blood disorders?		
10.	Have you had a heart, liver, or kidney, lung transplant?		

PATIENTS: If any "YES" answered above, STOP here. If ALL "NO's", please continue Part Two.

OFFICE STAFF: Any "YES" answered above, schedule further evaluation per the patients specialist, PCP or IMPACT.*

(PAT should be scheduled 7 to 10 days prior to surgery date.)

PAT VISIT

	Part Two:	YES	NO
1.	Do you take blood pressure medication?		
2.	Do you see a cardiologist?		
3.	Do you have asthma, emphysema, COPD?		
4.	Do you have sleep apnea? (Stop breathing during sleep)		
5.	Do you take diabetic medication by mouth?		
6.	Have you had a stroke or mini-stroke more than one year ago?		
7.	Do you take seizure medication?		
8.	Do you have HIV/AIDS?		
9.	Have you had chemotherapy or radiation in the past 3 months?		
10.	Do you or family members have a history of severe reaction to anesthesia? Malignant hyperthermia or high fever with anesthesia?		
11.	Do you take Methimazole or PTU (Propylthiouracil)?		
12.	Do you have chronic kidney disease or decreased kidney function?		
13.	Have you been hospitalized in the past 3 months for heart or lung issues?		
14.	Do you have a neuromuscular disease? Myasthenia Gravis, Muscular Dystrophy, Multiple Sclerosis, Parkinson		

Any **"YES"** answers in Part Two schedule **PAT visit.***

All **"NO"** answers or if patient had surgery at Gwinnett Medical in the past 6 months with no change in health status, call scheduling for **phone interview**: 678-312-4170.

Best Date/Time to Receive a Phone Call (4 hour window) _____(Between 07:30am—04:30pm)

***No PAT visit needed for:** Local Anesthesia, Cataracts, Prisoner, Nursing Home Patients, Stretcher Bound Patients, and Children >12 months and < 8 years (with no medical history).

Revised 08-15-14

SOUTHERN SURGICAL ASSOCIATES

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I, _____ have been informed that a copy if the Notice of Privacy Practices is posted in the waiting room and that a copy will be furnished to me upon my request.

_____ _____

Signature of Patient Date

HIPPA is an acronym for the Health Insurance Portability and Accountability Act of 1996 (a federal law). Of significant concern to healthcare providers is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

Privacy regulations over disclosure and use of health information.
Security regulations over protection of electronic health information.
Security regulations over electronic transmissions of health information.
Unique Identifiers for health plans, providers, individuals, employers.

It is our policy not to release confidential information by telephone, answering machine, voicemail, cell phone, pager, fax, or mail. Whenever returning phone calls and an answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the phone.

I authorize Southern Surgical Associates and staff to release medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

	(PLEASE CIRCLE)			(PLEASE CIRCLE)	
HOME TELEPHONE:	YES	NO	FAX:	YES	NO
ANSWERING MACHINE:	YES	NO	CELLPHONE:	YES	NO
WORK TELEPHONE:	YES	NO	VOICEMAIL:	YES	NO
VOICEMAIL:	YES	NO	MAIL:	YES	NO

If you would like to have information released to someone other than yourself, please complete the following:
Please list names of people we can discuss your medical care with:

	(PLEASE CIRCLE)	
SPOUSE: _____	YES	NO
RELATIVE: _____	YES	NO
OTHER: _____	YES	NO

_____ _____

SIGNATURE OF PATIENT / GUARDIAN DATE

TO ALL PATIENTS

PAYMENTS, CO-PAYMENTS, DEDUCTIBLES & CO-INSURANCE

Effective January 1, 2006, it is our policy that all **office visit** payments, co-payments, and deductibles are to be paid at the time of service.

Also, regardless of insurance carrier, all **surgical procedure** payments, co-payments, deductibles, and co-insurance are to be paid prior to surgery. Our financial counselor will review these arrangements with you.

_____ _____

SIGNATURE DATE