Stark County Surgeons, Inc
Patient Information

Today's Date:_____/_____/_____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Cell Phone: (_____) _____-_____ Other phone: (_____) _____-_____

E-Mail Address: _____

Employer: _____ Job Title: _____

Marital Status: M S D W Sep Spouse's Name: _____

Spouse's Employer_____ Phone (_____) _____-_____

Spouse's Date of Birth: _____/_____/_____ SS#: _____-_____-_____

Emergency Contact Name/Number:_____

Insurance

*Please present **all** insurance cards to the front office staff. Thank you!*

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits to which I am entitled to **Stark County Surgeons, Inc.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment will be considered as valid as the original.

I understand that I am financially responsible for all charges my dependents or I might incur. I hereby authorize **Stark County Surgeons, Inc.** to release any information acquired in the course of my treatment that is necessary to secure payment.

SIGNED: _____ DATE: _____

Stark County Surgeons, Inc
Patient History

Patient Name: _____ *Date:* _____

Date of birth: _____ *Age:* _____ *Gender:* **Male** **Female**

Height: _____ *Weight:*_____ *Any recent changes in weight?* **No** **Yes** *Amount?* _____ + or -

Who is your Primary Care Physician: _____

What symptoms are you having? _____

ALLERGIC TO:_____

ANTI-COAGULATION THERAPY: *Are you currently taking any of the following medications?*

Aspirin Coumadin Lovenox Plavix Heparin Pradaxa Aggrenox

MEDICAL HISTORY: *Please mark off any medical problems that you have.*

Heart disease
___ Heart Attack ___ Mitral Valve Prolapse
___ Arrhythmia ___ Coronary Artery Disease
___ Congestive Heart Failure

Endocrine
___ Diabetes
___ Thyroid

Liver problems
___ Cirrhosis
___ Hepatitis

Kidney problems
___ Stones
___ Chronic Disease
___ Renal failure
___ Dialysis

Circulatory
___ Anemia ___ Stroke
___ Blood clots ___ High BP
___ Varicose veins ___ Cholesterol

Lung disease
___ Asthma
___ Emphysema
___COPD

Urinary
___ Enlarged prostate
___ Incontinence
___ Frequent Infection

Intestinal problems
___ IBS ___ Diverticulitis
___ GI Bleed ___ Hemorrhoids
___ Ulcers ___ GERD
___ Colitis ___ Crohn's Disease

Arthritis
___ Knees
___ Shoulder
___ Rheumatoid

Cancer
___ Breast ___ Skin
___ Colon ___ Prostate
___ Lung _____

Gynecologic
___ Abnormal PAP
___ Endometriosis
___ Other

Psychological
___ Depression
___ Anxiety
___ Other

____Sleep Apnea
____ Immune-deficiency
____Other (list)_____
_____

SURGICAL HISTORY: *Please mark off any surgeries you have undergone* ***and the year they were done.*** .

____Gallbladder _____Appendectomy _____Tonsillectomy _____Thyroid* _____Brain* _____Lung* ____ Prostate*

_____Eye* ____ Kidney* ____ Bladder* ____ Vascular* ____ Ear/Nose/Throat* ____ Skin*

***(please be specific)**_____

_____

_____Hernia repair
___ Inguinal
___ Ventral
___ Umbilical
___ Incisional

_____Heart
___ Bypass
___ Stent
___ Valve
___ Pacemaker

____ Anorectal
___ Hemorrhoidectomy
___ Fissure
___ Abscess
___ Fistula

_____Intestinal
___ Colon
___ Small Bowel
___ Liver
___ Stomach
___ Other

____Gynecological
___ C-sections ___ ___ D&C
___ Tubal ligation
___ Hysterectomy partial (uterus only)
___ Hysterectomy, complete (uterus, tubes and ovaries)

_____Breast
___ Biopsy ____ Mastectomy
___ Lumpectomy ____ Reconstruction

____ Orthopedic
___ Joint replacement _____
___ Spinal ___ Arthroscopy

_____Any problems with anesthesia (list)_____
(post-surgery nausea; vomiting; difficulty waking up, etc.)

SOCIAL HISTORY:

Your Marital Status: (circle one) **Single Married Divorced Widowed**

How many children do you have? _____

Employer: _____ *Occupation:*_____

*Do you **currently** smoke?* **No Yes** *Packs per day?* _____ *How many years?* _____

*Did you smoke **in the past**?* **No Yes**. *If yes, when did you start, how many packs a day did you smoke, and when did you quit?*_____

Do you use chewing tobacco? **No Yes** *If Yes, how many times per day?* 1 2 3 4 5 6 7 8 9 10 more than 10

Alcohol? **Never Rarely** *(<2 / month)* **Occasionally** *(3-4 / month)* **Moderately** *(2-3x / week)* **Frequently** *(4-5x / week)* **Daily**

Drug abuse? **No Yes** What drug(s)? _____

CHRONIC PAIN

Do you have chronic pain? **No Yes** Where? _____

Do you see a chronic pain specialist? _____

REVIEW OF SYSTEMS:
Are you having any problems in these areas?

___ Vision___ Ear, nose, throat___ Heart___ Lungs Please explain: _____

___ Intestinal___ Muscles/skeletal___ Skin___ Breasts _____

___Genito-urinary____ Neurologic___ Vascular _____

___ Hormonal ___ Immune system____ Psychiatric _____

FAMILY HISTORY: *Please mark any illness or chronic medical conditions that affect an immediate, related family member, and the person's relationship to you (mother, father, sibling, etc)*

_____Heart disease _____Cholesterol _____Blood pressure _____Diabetes _____Thyroid

_____Cancer of _____ _____Other (list)_____

FEMALE PATIENTS - GYNECOLOGICAL HISTORY:

*Number of pregnancies*_____ *Number of children*_____ *C-sections*_____

Any problems with pregnancies? **No Yes**_____

Menopause? **Yes No** *Date of last menstrual period* _____

_____ _____

Signature **Date**

MEDICATION RECORD

Please include Prescriptions, Vitamins, Supplements and over-the-counter meds.

Date:_____

Patient Name: _____

Medication	**Dosage**	**Frequency**

Stark County Surgeons, Inc
Financial Policy

Thank you for choosing us to be your health care provider. We are committed to your successful treatment. This is our financial policy, which we require you to read and sign prior to any treatment.

This office accepts most insurance companies. Prior to your appointment it is your responsibility to check with your insurance company to be sure our doctors are on your plan.

Financial Responsibility
Your financial responsibility is based on the coverage you have with your insurance company. Co-pays are due at the time of service. Deductibles will be collected prior to scheduled procedures or surgeries.

We offer the following flexible payment options...
Cash, Check, Credit Card, also automatic monthly payments from credit card.

The following situations **require payment in full** prior *to seeing the Doctor*:

- Self-Pay
- Motor Vehicle Accident or Other Liability Accident
- Non-Pre-Certified Second Opinion
- Cosmetic Procedures

Please be aware that your insurance policy is a contract between you and your insurance company, and we are NOT a party to that contract. While we will work with your insurance to secure payment on your behalf, YOU are ultimately responsible for the bill. We CANNOT guarantee payment of your claims.

UCR (Usual, Customary & Reasonable) is a term created by insurance companies to *arbitrarily* decrease the payments that they make. Unless we have a contract with your insurance company, we are NOT bound by this reduction, and you will be responsible for any unpaid portion of your bill.

I have read and understand the above Financial Policy, and agree to this Policy.

_____ _____

Signature of Patient/Responsible Party Date