

RALEIGH SURGICAL GROUP – Patient Questionnaire

NAME _____ DATE _____
 REASON FOR VISIT TODAY _____
 DOCTOR WHO SENT YOU TO US _____
 PRIMARY CARE DOCTOR _____

Past Medical History

Please check all medical problems you have had in the past:

- Abdominal aortic aneurysm
- Alcoholism
- Alzheimer's disease
- Anemia
- Angina
- Arthritis
- Asthma
- Blood clot in leg or lung
- Bronchitis
- Coronary artery disease
- Cancer
TYPE _____
- Cardiac catheterization
- Cataracts
- Cirrhosis
- Colon polyps
- Crohn's disease
- Depression
- Diabetes
- Diverticulitis or diverticulosis
- Emphysema
- Endometriosis
- Fibromyalgia
- Glaucoma
- Gout
- Headaches
- Hearing loss
- Heart attack
- Heart beat irregular
- Heart murmur
- Hemorrhoids
- Hepatitis
- High cholesterol
- HIV/AIDS
- High blood pressure
- Irritable bowel syndrome
- Kidney failure
- Kidney stones
- Liver disease
- Mitral valve prolapse
- Osteoporosis
- Parkinson's disease
- Pelvic inflammatory disease
- Pneumonia
- Reflux
- Seizures
- Sickle cell disease
- Stroke
- Thyroid problem
- Transfusion
- Transplant
- Tuberculosis
- Ulcerative colitis
- Ulcer
- Vision loss
- OTHER _____

Past Surgical History

Please list all operations you have had in the past: NONE

Medications

Please list all medications you are presently taking (include doses): NONE

Allergies

Please list all medicines you are allergic to or have a reaction to: NONE

Family Medical History

Please list all medical problems which run in your family:

Habits

Do you smoke cigarettes?
 no occasionally 1/2 ppd 1 ppd
 If you smoked in the past, when did you quit?

 Do you drink alcohol?
 never occasionally
 a few times a week daily

Have you recently had any of the following symptoms? Please check all that apply :

	<u>NO</u>	<u>YES</u>
<u>GENERAL</u>		
weight loss	<input type="checkbox"/>	<input type="checkbox"/>
fever	<input type="checkbox"/>	<input type="checkbox"/>
sweats	<input type="checkbox"/>	<input type="checkbox"/>
chills	<input type="checkbox"/>	<input type="checkbox"/>
decreased appetite	<input type="checkbox"/>	<input type="checkbox"/>
fatigue	<input type="checkbox"/>	<input type="checkbox"/>
<u>EYES</u>		
loss of vision	<input type="checkbox"/>	<input type="checkbox"/>
double vision	<input type="checkbox"/>	<input type="checkbox"/>
<u>EARS/NOSE/THROAT</u>		
hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
nosebleed	<input type="checkbox"/>	<input type="checkbox"/>
sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>
hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
sore throat	<input type="checkbox"/>	<input type="checkbox"/>
trouble swallowing	<input type="checkbox"/>	<input type="checkbox"/>
<u>LUNGS</u>		
chronic cough	<input type="checkbox"/>	<input type="checkbox"/>
coughing blood	<input type="checkbox"/>	<input type="checkbox"/>
painful breathing	<input type="checkbox"/>	<input type="checkbox"/>
recent cold	<input type="checkbox"/>	<input type="checkbox"/>
shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
coughing phlegm	<input type="checkbox"/>	<input type="checkbox"/>
wheezing	<input type="checkbox"/>	<input type="checkbox"/>
<u>HEART</u>		
irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>
chest pain	<input type="checkbox"/>	<input type="checkbox"/>
swelling in feet	<input type="checkbox"/>	<input type="checkbox"/>
<u>STOMACH/INTESTINES</u>		
abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
abdominal bloating	<input type="checkbox"/>	<input type="checkbox"/>
constipation	<input type="checkbox"/>	<input type="checkbox"/>
diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
change in stools	<input type="checkbox"/>	<input type="checkbox"/>
heartburn	<input type="checkbox"/>	<input type="checkbox"/>
nausea	<input type="checkbox"/>	<input type="checkbox"/>
rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
vomiting	<input type="checkbox"/>	<input type="checkbox"/>
<u>KIDNEYS/GENITALS</u>		
painful urination	<input type="checkbox"/>	<input type="checkbox"/>
bloody urine	<input type="checkbox"/>	<input type="checkbox"/>
impotence	<input type="checkbox"/>	<input type="checkbox"/>
<u>MUSCLES/BONES</u>		
joint pain	<input type="checkbox"/>	<input type="checkbox"/>
arthritis	<input type="checkbox"/>	<input type="checkbox"/>
<u>NERVES</u>		
headache	<input type="checkbox"/>	<input type="checkbox"/>
numbness	<input type="checkbox"/>	<input type="checkbox"/>
tingling	<input type="checkbox"/>	<input type="checkbox"/>
<u>SKIN</u>		
jaundice	<input type="checkbox"/>	<input type="checkbox"/>
rash	<input type="checkbox"/>	<input type="checkbox"/>
<u>BREAST</u>		
breast discharge	<input type="checkbox"/>	<input type="checkbox"/>
breast pain	<input type="checkbox"/>	<input type="checkbox"/>
<u>PSYCHIATRIC</u>		
depression	<input type="checkbox"/>	<input type="checkbox"/>
insomnia	<input type="checkbox"/>	<input type="checkbox"/>
<u>BLOOD</u>		
easy bleeding	<input type="checkbox"/>	<input type="checkbox"/>
enlarged lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>
OTHER _____		

PATIENT REGISTRATION

(Please Print)

CHART # _____

PATIENT FULL NAME _____
(LAST) (FIRST) (MIDDLE)

MAILING ADDRESS _____

(STREET OR ROUTE) _____ CITY STATE ZIP

BIRTHDATE _____ AGE _____ SEX _____ MARITAL STATUS _____ CITY STATE ZIP

SOCIAL SECURITY # _____

TELEPHONE (home) (____) _____ (work) (____) _____ (cell) (____) _____

WHICH DOCTOR ARE YOU GOING TO SEE? _____

WHICH DOCTOR REFERRED YOU TO US? _____ (PHONE #) _____

FAMILY DOCTOR _____ ADDRESS _____

REASON FOR OFFICE VISIT _____

EMPLOYER _____ OCCUPATION _____

EMPLOYERS ADDRESS _____

PARENT OR SPOUSE'S NAME _____

PARENT OR SPOUSE'S EMPLOYER _____

PARENT OR SPOUSE'S BUSINESS PHONE _____

I PLAN TO MAKE PAYMENT OF MY MEDICAL EXPENSES AS FOLLOWS: CASH/CHECK MASTER CARD/VISA

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:

I authorize treatment of the person named above and agree to pay all charges for such treatment. I agree to pay all charges for me and all dependents shown by statements, promptly upon presentation thereof, unless credit arrangements are agreed upon in writing. It is agreed that payment will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.)

Signature _____ Date _____
RESPONSIBLE PERSON

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the physician to release any information acquired in the course of my examination or treatment to specific insurance carriers, third party payers or others involved in processing and collection of this claim.

Signature _____ Date _____

ACKNOWLEDGMENT OF PRIVACY PRACTICES:

I hereby acknowledge that I have received a copy of Raleigh Surgical Group's Notice of Privacy Practices. This notice describes how information about me may be used or disclosed, in accordance with the Health Insurance Portability and Accountability Act (HIPAA)

Signature _____ Date _____

EMERGENCY CONTACT INFORMATION: I authorize Raleigh Surgical Group to contact the person listed below in case of

emergency and/or regarding test results, health information and financial issues.

Name: _____ Relationship: _____

Patient Signature: _____ Daytime Phone #: _____

THIS FORM MUST BE COMPLETED

INSURANCE INFORMATION

Primary Insurance Company Name _____

Policyholder's Name _____ Date of Birth _____

Policyholder's Phone # Home _____ Work _____

Policyholder's Address _____

City _____ State _____ Zip Code _____

Certificate or ID # _____ Group _____

SS# _____ Policyholder's Employer _____

Mail Claim form to: _____

Secondary Insurance Company Name _____

Policyholder's Name _____ Date of Birth _____

Policyholder's Phone # Home _____ Work _____

Policyholder's Address _____

City _____ State _____ Zip Code _____

Certificate or ID # _____ Group _____

SS# _____ Policyholder's Employer _____

Mail Claim form to: _____

ALL COPAYS MUST BE MADE AT TIME OF VISIT