SURGICAL SERVICES of ATHENS

REGISTRATION FORM

Please Print and Fill Out Completely

DATE: _____ SSN: _____ DOB: _____

LAST NAME: _____ FIRST NAME: _____ MIDDLE NAME: _____

AGE: _____ PRIMARY CARE PROVIDER: _____

SEX: [] Male [] Female [] Other MARITAL STATUS: [] Single [] Married [] Separated [] Divorced [] Widowed

HOME PHONE: _____ MOBILE PHONE: _____ WORK PHONE: _____

ADDRESS STREET: _____ APT#: _____ P.O. BOX: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMAIL ADDRESS: _____ OCCUPATION: _____

EMPLOYER: _____

REFERRED BY: [] Self-Referred [] Health Care Provider _____ [] Emergency Room

[] Family [] Friends [] Website [] Yellow Pages [] Other _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Subscriber's Name (if different from patient) _____ Relationship: [] Spouse [] Parent [] Other

Subscriber's DOB _____ Subscriber's SSN _____

Group # _____ Policy # _____ Co-Payment (If Known) $ _____

SECONDARY INSURANCE

Subscriber's Name (if different from patient) _____ Relationship: [] Spouse [] Parent [] Other

Subscriber's DOB _____ Subscriber's SSN _____

Group # _____ Policy # _____ Co-Payment (If Known) $ _____

If patient is a minor, person responsible for patient: _____

Is this a Workman's Comp case?: _____ If Workman's Comp, accident date: _____

EMERGENCY CONTACT

Name _____ Relationship _____

Home Phone _____ Mobile Phone _____

I hereby assign, transfer, and overturn to Noel General Surgery PC, Seth D. Rayburn MD PC, or Koonce Surgical PC, all rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the unlikely event this account is submitted for collection, I the undersigned agree to pay any and all collection costs and reasonable attorney fees. Copays are due at the time of the office visit. A copy of the Privacy Practices for Noel General Surgery PC, Seth D. Rayburn MD PC, or Koonce Surgical PC is available upon request.

Patient's Signature: _____ Date: _____

NAME: _____ DOB: _____

SURGICAL SERVICES of ATHENS

MEDICAL HISTORY

CURRENT CARE PROVIDERS: _____

_____

_____

PLEASE MARK IF YOU HAVE OR HAD THE FOLLOWING:

- [] Acute Hepatitis
- [] Alzheimer's Disease / Dementia
- [] Anemia
- [] Anxiety
- [] Arthritis
- [] Asthma
- [] Atrial Fibrillation
- [] Bleeding Disorders
- [] Blood Clots (DVT)
- [] Cancer Type _____
- [] Chronic Cough
- [] Cirrhosis
- [] COPD / Emphysema
- [] CVA (Stroke) YEAR _____
- [] Depression
- [] Diabetes
- [] Fibromyalgia
- [] Heart Attack (MI) YEAR _____
- [] Heart / Coronary Artery Disease
- [] Heart Valve Disease
- [] High Cholesterol
- [] HIV
- [] Hypertension
- [] IBD (Crohn's Disease/Ulcerative Colitis)
- [] Liver Disease
- [] Multiple Sclerosis
- [] Nervous Disorder
- [] Neuropathy
- [] Renal Insufficiency / Failure
- [] Seizure Disorder
- [] Sleep Apnea
- [] Thyroid problems
- [] TIA (Mini-Stroke)

OTHER MEDICAL CONDITIONS:

_____

_____

_____

_____

_____

SURGICAL HISTORY:

- [] Appendectomy (Appendix Removal)
- [] Back / Neck Surgery
- [] Bladder / Kidney Stone Surgery
- [] Breast Biopsy
- [] CABG (Open Heart Surgery)
- [] Carpal Tunnel Surgery
- [] Cataract Surgery
- [] Cholecystectomy (Gallbladder Removal)
- [] Colon Resection
- [] Colonoscopy
- [] C-Section
- [] D&C
- [] Dialysis Access Surgery
- [] EGD
- [] Exploratory Surgery
- [] Foot Surgery
- [] Fundoplication (Anti-Reflux Surgery)
- [] Gastric Band
- [] Gastric Bypass
- [] Gastric Sleeve
- [] Heart Stents
- [] Heart Valve Replacement
- [] Hemorrhoid Surgery
- [] Hernia Repair
- [] Hysterectomy
- [] Joint Replacement
- [] Kidney Transplant
- [] Knee Surgery
- [] Lung Surgery
- [] Mastectomy (Breast Removal)
- [] Nephrectomy (Kidney Removal)
- [] Pacemaker / Defibrillator
- [] Prostatectomy (Prostate Removal)
- [] Shoulder Surgery
- [] Sinus Surgery
- [] Skin Cancer Surgery
- [] Splenectomy (Spleen Removal)
- [] Tonsillectomy / Adenoidectomy
- [] Tubes in Ears (Tympanostomy Tubes)
- [] Vasectomy

OTHER PRIOR SURGERIES:

_____

_____

_____

_____

NAME: _____ DOB: _____

FAMILY HISTORY: (Has anyone in your family had any of the following?)

[] Adopted / Unknown Family History
[] Bleeding Disorders
[] Cancer Type _____
[] Colon Polyps
[] Congestive Heart Failure
[] CVA (Stroke)
[] Heart Attack (MI)
[] High Blood Pressure
[] IBD (Crohn's Disease / Ulcerative Colitis)
[] Kidney Disease

SOCIAL HISTORY	YES	NO
Do you smoke cigarettes, cigars, or a pipe? If yes, daily amount _____		
Did you smoke in the past? If yes, when did you quit? _____		
Do you vape?		
Do you use smokeless tobacco?		
Do you use any illicit substances? If yes, what substance? _____		
Do you drink alcohol? If yes, [] Rarely [] Socially [] Regularly / Amount _____		
Do you have a living will?		
Cultural or Religious requirements? (e.g. refusal of blood products) _____		

Household Situation: [] Live Alone [] Spouse / Family [] Roommates [] Other

Current Residence: [] Home [] Apartment / Condo [] Mobile Home [] Other

Do you currently use a Home Health Agency? If so, which agency? _____

Do you use any of the following?

[] Cane
[] Contact Lenses
[] CPAP Device
[] Crutches
[] Dentures
[] Glasses
[] Hearing Aid
[] Home Oxygen
[] Hospital Bed
[] Nebulizer
[] Walker
[] Wheelchair

Medications:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Preferred Pharmacy: _____ Pharmacy Phone: _____

Allergies: [] Tape / Adhesives [] Latex [] Seasonal Allergies

Medication Allergies:

_____ _____
_____ _____
_____ _____

NAME: _____ DOB: _____

REVIEW OF SYSTEMS

GENERAL
- [] Fatigue
- [] Fever / Chills
- [] Night Sweats
- [] Weakness
- [] Weight Gain
- [] Weight Loss

SKIN
- [] Atypical Lesions or Moles
- [] Rashes
- [] Sores or Ulcers

HEENT
- [] Decreased Hearing
- [] Earache
- [] Headache
- [] Hoarseness
- [] Loss of Vision
- [] Ringing in Ears

HEART / CARDIOVASCULAR
- [] Chest Pain
- [] Heart Murmur
- [] Palpitations
- [] Swelling of the Legs or Feet

PULMONARY
- [] Cough (Acute)
- [] Cough (Chronic)
- [] Hemoptysis (Blood In Sputum)
- [] Shortness of Breath
- [] Wheezing

BREASTS
- [] Breastfeeding Currently
- [] Mass
- [] Nipple Discharge
- [] Pain

EXTREMITIES
- [] Joint Pain
- [] Leg Pain
- [] Swelling
- [] Weakness

GI
- [] Abdominal Pain
- [] Bloating
- [] Blood in Stool
- [] Constipation
- [] Dark, Tarry Stool
- [] Diarrhea
- [] Difficulty Swallowing
- [] Fecal Incontinence
- [] Heartburn / Reflux
- [] Nausea / Vomiting

GU
- [] Blood in Urine
- [] Discharge
- [] Frequent Urination
- [] Pain or Burning with Urination
- [] Urinary Incontinence
- [] If Female:

Age of First Menstrual Cycle

_____

Date of Last Menstrual Cycle

_____

Age of First Pregnancy

_____

NEUROLOGIC
- [] Fainting
- [] Paralysis
- [] Neuropathy
- [] Seizures

PSYCHIATRIC
- [] Anxiety
- [] Panic Attacks
- [] Depression

NAME: _____ DOB: _____

SURGICAL SERVICES of ATHENS

HIPAA AUTHORIZATION

For Release of Medical Information

I, _____ do hereby grant permission for my personal healthcare information to be discussed with and/or released to the following persons:

APPOINTMENT INFORMATION:

Name _____ Relationship _____

Name _____ Relationship _____

MEDICAL INFORMATION (Diagnosis / Treatment / Prescription / Lab Results):

Name _____ Relationship _____

Name _____ Relationship _____

FINANCIAL AND INSURANCE INFORMATION:

Name _____ Relationship _____

Name _____ Relationship _____

Signature _____

Date _____ Relationship of Signer (If applicable) _____