



Center of Surgical Specialists, P.C.

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GENERAL, VASCULAR, THORACIC, ADVANCED LAPAROSCOPIC, BARIATRIC AND SPINE ACCESS SURGERY

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PATIENT INFORMATION FORM

Please fill out completely

Name of Patient: First Middle Last Date of Birth Sex Marital Status

Address: City: State: Zip:

Home phone: Cell phone: Work Phone:

Social Security Number: Driver's License#: Email:

Employer: Occupation:

Employment Address: May we contact you at work? (Circle) Yes No

Emergency Contact: Name: Relationship:

Home Phone: Work Phone:

Who Referred you to our office?

Name: Phone:

Address: City: State: Zip:

Primary Care Physician:

Name: Phone:

Address: City: State: Zip:

\*\*\*In order to avoid error or delay in the processing of your insurance claim, it is essential that the following section be filled out completely.

PRIMARY INSURANCE COMPANY

SECONDARY INSURANCE COMPANY

Name:

Name:

Member ID Number:

Member ID Number:

Group Number: Copay:

Group Number: Copay:

Name of Insured (employee):

Name of Insured (employee):

Employer:

Employer:

Employer Phone:

Employer Phone:

Insured's Social Security:

Insured's Social Security:

Insured's Date of Birth:

Insured's Date of Birth:

It is my responsibility to pay any copayment, deductible amount, co-insurance or any other balance not paid by my insurance. Finance charges (at an annual rate not to exceed 18%) on unpaid balances will be added to my account after 90 days. If it becomes necessary for my account to be turned over to a collection agency, I understand that collection fees will be added to my balance. I understand I will be responsible to pay all collections fees, attorney fees and court costs.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and other health plans to: Center of Surgical Specialists, PC. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information, including medical history and medical records, to my insurance company.

PATIENT SIGNATURE

DATE

Update:

DATE: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**ALLERGIES:** Are you allergic to any medications (including over-the-counter drugs or iodine, tape or latex)?  
Circle one: Yes No If yes, please complete the following:

Drug Allergy:                      Reaction:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other Allergy:                      Reaction:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL PROBLEMS:** Please list all medical problems you have.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS:** Please list all medications (specify dosage and frequency) you are currently taking, including aspirin, over-the-counter medications, vitamins and herbal supplements.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list your PAST medications.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OPERATIONS:** Please list all operations you have had.

Operation:                                      Date:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Operation:                                      Date:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY:**

Do you use any type of tobacco product?      Yes      No      If yes, how much per day \_\_\_\_\_  
Have you EVER used any type of tobacco product?      Yes      No      Date Quit \_\_\_\_\_  
Do you drink alcohol?      Yes      No      If yes, how often? \_\_\_\_\_  
Do you use illicit drugs?      Yes      No      If yes, please list: \_\_\_\_\_  
For women: Last menstrual period: \_\_\_\_\_      Number of Pregnancies: \_\_\_\_\_      Number of Live Births: \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_