Rana Ahmad, MD - Timothy Bax, MD
Steven Beyersdorf, MD - J. Courtney Clyde, MD
Kimberly Hartnett, MD - Adam Juviler, MD

SURGICAL SPECIALISTS of Spokane

Paul Lin, MD - Mark MacFarlane, MD
Shane McNevin MD -Emily Mildes, ARNP
Michael Moore, MD - Jonathan Nickoloff, MD

Patient Information Profile

Reason for Surgical Appointment: ______________________ SSN: ______________

Patient Name: F: __________ MI: _____ L: ______________ DOB: __________ Age: ____

Physical Address: ______________________ Gender: M______ F ______

Mailing Address: ______________________

City: ______________ ST: ______ Zip Code: ________

Contact Phone: ____________ Cell Phone: ____________

Emergency Contact & Relationship: ______________ Emergency Phone: ____________

Primary Physician (aka PCP): ______________________

Referring Physician: ______________________

E-mail Address: ______________________

Race / Ethnicity

Preferred Language: ______________

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race:
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Hawaiian Native/Pacific Islander
- ☐ White
- ☐ Unspecified

Family History of Disease

Please check if applies and who in your family had the disease:

- ☐ Heart Disease ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ Lung Disease ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ Diabetes ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ Cancer: Site __________ Type __________
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ *Other:* ______________________
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ *Other:* ______________________
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ **NO KNOWN FAMILY HISTORY**

Medications/Dosage:

Preferred Pharmacy: / Location:

____

Medications/Dosage:

1) ______________________

2) ______________________

3) ______________________

4) ______________________

5) ______________________

6) ______________________

7) ______________________

8) ______________________

Social History

Marital Status:

Married ☐ Single ☐ Divorced ☐ Widowed ☐
Significant Other ☐ Life Partner ☐ Separated ☐

Occupation: ______________________

Employer: ______________________

Work Phone: __________ ext.

Habits (Check if applicable)

Smoker Status:
- ☐ Current everyday smoker
- ☐ Current some day smoker
- ☐ Smoker, current status unknown
- ☐ Never smoker
- ☐ Former smoker

Uses Tobacco:
- ☐ Current
- ☐ Former
- ☐ Unknown
- ☐ Never

Type __________ Units/day ______ Years used ____

Smoking cessation attempts? ☐ yes ☐ no

Year quit ________ Longest tobacco free

Relapse reason ______________________

Passive smoke exposure? ☐ yes ☐ no

Drug Use:

☐ Never ☐ Occasional ☐ Previously

Alcohol Use: Frequency (choose one)

- ☐ Beer ☐ Daily
- ☐ Wine ☐ Weekly
- ☐ Hard Liquor ☐ Monthly
- ☐ Previous drinker Yr Quit ________

PAST MEDICAL HISTORY:

Please check all that apply

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Benign prostatic hypertrophy
- ☐ Bleeding disorder
- ☐ Blood clots
- ☐ Blood transfusion
- ☐ Cancer TYPE: ______________
- ☐ Cardiac arrest
- ☐ Cardiac dysrhythmias
- ☐ Cardiac valvular disease
- ☐ Cerebrovascular accident
- ☐ COPD
- ☐ Coronary artery disease
- ☐ Crohn's Disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ DVT *(Deep vein thrombosis)*
- ☐ Endocarditis
- ☐ Gallbladder disease
- ☐ GERD
- ☐ Hemoglobinopathy
- ☐ Hepatitis C
- ☐ HIV/AIDS
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Inflammatory bowel disease
- ☐ Liver disease
- ☐ Malgrant hyperthermia
- ☐ Migraine headaches
- ☐ MRSA/VRE
- ☐ Myocardial infarction
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peptic ulcer disease
- ☐ Psychosis
- ☐ Pulmonary fibrosis
- ☐ Radiation
- ☐ Renal disease
- ☐ Seizure disorder
- ☐ Sleep apnea
- ☐ Thyroid disease

Others:

____

____

ALLERGIES:

No known allergies: ☐

Are you allergic to:

- *Latex* ☐
- *Surgical gloves* ☐
- *Iodine* ☐

Others:

1) ______________________

2) ______________________

3) ______________________

4) ______________________

5) ______________________

6) ______________________

PAST SURGICAL HISTORY:

Please check all that apply (include years if possible)

	Surgery:	Year:	Hospital:
☐	AICD insertion		
☐	Angioplasty		
☐	Angio w/ stent		
☐	Appendectomy		
☐	Arthroscopy knee		
☐	Back surgery		
☐	Breast biopsy		
☐	Bilateral tubal ligation		
☐	CABG		
☐	Carpal tunnel release		
☐	Cataract extraction		
☐	Cholecystectomy		
☐	Colectomy		
☐	Colostomy		
☐	ESWL		
☐	Gastric bypass		
☐	Gender reassignment		
☐	Hemorrhoidectomy		
☐	Herniorrhaphy		
☐	Hip replacement		
☐	Knee replacement		
☐	Laparoscopy		
☐	Laparotomy		
☐	LASIK		
☐	Liver biopsy		
☐	Nephrectomy		
☐	Organ transplant		

	Surgery:	Year:	Hospital:
☐	ORIF		
☐	Pacemaker		
☐	Small bowel resection		
☐	Thyroidectomy		
☐	Tonsillectomy		
☐	Valve replacement		

Others:

____

____

Gender Specific:

	Surgery	Year	Hospital
☐	Breast augmentation		
☐	Breast reduction		
☐	Cesarean section		
☐	D and C		
☐	Hysterectomy		
☐	Mastectomy		
☐	Myonectomy		
☐	Penile Implant		
☐	Prostate biopsy		
☐	TAH/BSO *(abdominal hysterectomy/oophorectomy)*		
☐	TLRP *(laparoscopic radical parametrectomy)*		
☐	Vaginal hysterotomy		
☐	Vasectomy		

REVIEW OF SYSTEMS:

Do you, or have you had, any problems related to the following systems? Please check if applicable.

CONSTITUTIONAL
- ☐ Chills/Shakes
- ☐ Decreased Appetite
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Loss

EYES/EARS/NOSE/MOUTH/THROAT
- ☐ Headache
- ☐ Hearing Loss
- ☐ Visual Loss
- ☐ Nose Bleeds *(Epistaxis)*
- ☐ Voice Change *(i.e.,Hoarseness)*
- ☐ Dysphagia
- ☐ Odynophagia
- ☐ Snoring

RESPIRATORY
- ☐ Shortness of Breath *(Dyspnea)*
- ☐ Coughing Blood
- ☐ Wheezing
- ☐ Frequent Upper Respiratory Infections
- ☐ Known TB Exposure

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Nocturnal Dyspnea *(waking up with SOB)*
- ☐ Orthopena *(SOB when sleeping)*
- ☐ Irregular Heartbeats/Palpitations
- ☐ Fainting *(Syncope)*

VASCULAR
- ☐ Claudication
- ☐ Edema
- ☐ Ulcer

Women Only: *(please complete)*

Pregnant now: ☐ yes ☐ no

Last menstrual period: __/__/__

Age of menarche: ______

\# of children: _______

Age at 1st child's birth: ______

Age at onset of menopause: ______

GASTROINTESTINAL
- ☐ Abdominal Mass
- ☐ Abdominal Pain
- ☐ Blood in Stool
- ☐ Change in Bowel Habits
- ☐ Diarrhea
- ☐ Fecal Incontinence
- ☐ Heartburn
- ☐ Hematemesis *(vomiting blood)*
- ☐ Jaundice *(yellowish skin)*
- ☐ Melena *(black stools)*
- ☐ Nausea
- ☐ Vomiting

GENITOURINARY
- ☐ Change in urine color
- ☐ Dysuria *(painful urination)*
- ☐ Groin Mass
- ☐ Hematuria *(blood in urine)*
- ☐ Urinary Incontinence
- ☐ Passage stone/gravel
- ☐ Decreased urine output

REPRODUCTIVE
- ☐ Menarche Age______
- ☐ Menses
- ☐ Post Menopausal
- ☐ Hormone Replacement Therapy
- ☐ Breast Discharge
- ☐ Breast Lumps
- ☐ Breast Pain

METABOLIC/ENDOCRINE
- ☐ Cold Intolerance
- ☐ Excessive Diaphoresis
- ☐ Goiter
- ☐ Gynecomastia

NEURO/PSYCHIATRIC
- ☐ Seizures
- ☐ Visual Changes
- ☐ Incontinence

DERMATOLOGIC
- ☐ Change in Mole
- ☐ Skin Lesion

HEMATOLOGIC
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Thromboembolic Events
- ☐ Transfusion

INSURANCE INFORMATION - *Please read the following sections carefully*

Medicare, Medicaid, and Tricare patients only:

I request the payment of authorized Medicare benefits be made either to me or on my behalf to Surgical Specialists of Spokane for any services received by that physician/supplier. I authorize any holder of medical information about me to release to the Centers of Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: Date:

As a courtesy, we bill your insurance company. In some cases, unless you are insured under worker's compensation, you may be responsible for up to the full amount of the charges incurred during your visit. If the doctor you are seeing is a contracted provider under your insurance plan, you may wish to discuss your financial responsibility with the member services department at your insurance company.

I hereby authorize my physician at Surgical Specialists of Spokane to release any information obtained in the course of my examination that my insurance company may request. I also authorize assignment of my medical benefits to my physician at Surgical Specialists of Spokane. This assignment of benefits allows our office to collect directly from your insurance company. Without this release, you will be require to pay for your visit at the time the services are rendered.

I understand that I may be responsible for paying for services rendered, including reasonable attorney's fees and costs incurred in the event of any default. The information provided on this form is complete and accurate to the best of my knowledge.

Signature: Date:

WORK OR AUTOMOBILE RELATION INJURY

Is this visit a result of an injury? ☐ Yes ☐ No Date of Injury: ____

Work related? ☐ Yes ☐ No Other (please explain): ____

Insurance Carrier Name: ____ Claim Number: ____

Insurance Phone: ____ Insurance Address: ____

Employer at time of injury:

PRIMARY INSURANCE *(indicated by a "P" in the last question)*

Company: ____ Insurance Address: ____

Name of Insured: ____ Policy Number: ____

Insured's SSN: ____ *DOB:* ____ Group Number: ____

Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Dependent ☐ Other; please explain:

SECONDARY INSURANCE *(indicated by an "S" in the last question)*

Company: ____ Insurance Address: ____

Name of Insured: ____ Policy Number: ____

Insured's SSN: ____ *DOB:* ____ Group Number: ____

Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Dependent ☐ Other; please explain:

TERTIARY INSURANCE *(indicated by a "T" in the last question)*

Company: ____ Insurance Address: ____

Name of Insured: ____ Policy Number: ____

Insured's SSN: ____ *DOB:* ____ Group Number: ____

Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Dependent ☐ Other; please explain:

NO SHOW POLICY

Surgical Specialists of Spokane has a "No Show" policy for missed appointments. An appointment is considered a "No Show" if you do not attend a scheduled appointment and do not cancel by 5 PM the previous business day. The fee for a "No Show" appointment is $25.00 and will be effective after the second missed appointment. This will not be billed to your insurance company. It is the patient/family responsibility and will be billed directly to the patient.

WOUND CARE PATIENTS ONLY: If you cannot keep your scheduled appointment and do not cancel 24 hours prior, it jeopardizes another patient from being able to fill the time slot. If you fail to show up for a scheduled appointment 3 times, at our discretion, we may cancel you from our clinic and refer you to the Deaconess Hospital wound care clinic for further services and care.

I understand and agree to the above policy.

SELF PAY / NO INSURANCE POLICY

Payment in full is expected at the time of service. If that is not possible, we will accept $175 payment at the time of your first consultation visit to be applied to the charges incurred. It is by no means the total cost of the visit, only a down payment. Payment arrangements need to be made through our billing department. 252-2838

DELAYED COPAYMENT POLICY

Surgical Specialists of Spokane has a "Delayed Copayment" policy for copayments not paid at time of service. As a courtesy, we will bill you for copayments not paid during the check-in process; however, Surgical Specialists of Spokane reserves the right to include an administrative fee of $25.00. This will not be billed to your insurance company. It is the patient/family responsibility and will be billed directly to the patient.

I understand and am aware of ALL of the above policies.

Signature: ______________________________ Date: ________________

NOTICE OF PRIVACY PRACTICES and IDENTITY THEFT- ACKNOWLEDGEMENT

We need to have permission from the patient or parent/legal guardian to discuss anything related to the patient's healthcare, including appointment information, financial matters, or health history with any member of the patient's family.

Do we have permission to:

Leave a voicemail message on the contact (home) phone?	☐ Yes	☐ No
Leave a voicemail message on the cell phone (if given)?	☐ Yes	☐ No
Leave a message at your place of employment?	☐ Yes	☐ No
Discuss the patient's medical condition with any member of the family?	☐ Yes	☐ No

If "Yes," then whom, and what is their relationship to the patient:

Name: ______________________________ Relationship ________________

Name: ______________________________ Relationship ________________

Name: ______________________________ Relationship ________________

I have been offered today, or in the past, the Notice of Privacy Practices and the Notice of Identity Theft from Surgical Specialists of Spokane.

Signature: ______________________________ Date: ________________

Printed name if signed on behalf of the patient: ______________________________

Relationship to the patient: ______________________________

Surgical Specialists of Spokane Employee Witness: ______________________________

Thank you for taking the time to fill out these forms. We look forward to serving you!