DALLAS SURGICAL SPECIALISTS
GREATER TEXAS

Please circle the Physician you will be seeing today.

Randall Kirby, MD Julianne Santarosa, MD Donald Reed Jr, MD Gerson Pineda, MD

PATIENT NAME:_____

SS#_____SEX:___M ___F MARITAL STATUS:_____

DATE OF BIRTH:_____AGE:_____

ADDRESS:_____ APT#_____

CITY:_____STATE:_____ZIP:_____

HOME PHONE#_____CELL PHONE#_____

WORK PHONE#_____OTHER CONTACT#_____

EMPLOYER:_____OCCUPATION:_____

EMERGENCY CONTACT:_____

TELE#_____RELATIONSHIP TO PATIENT:_____

REFERRING DOCTOR:_____ TELE#_____

PRIMARY DOCTOR: _____ TELE#_____

MEDICAL INSURANCE INFORMATION

WERE YOU INJURED WHILE AT WORK?_____ WHEN?_____

DO YOU HAVE MEDICARE?___YES___NO MEDICARE#_____

DO YOU HAVE MEDICAID?___YES____NO MEDICAID#_____

DO YOU HAVE MEDICAL INSURANCE? YES___NO____

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

All fees for professional services rendered by Dallas Surgical Specialist are charged to the patient. Dallas Surgical Specialist is a participating provider with Medicare. We agree to accept Medicare assignment and the patient is only held liable for the 20% not covered by Medicare. As a courtesy necessary forms will be completed to help expedite health Insurance payment. However, the patient will be responsible for all fees, regardless of insurance coverage. Any insurance claim not paid by the patients insurance companies in 60 days are billed directly to the patient. The patient may then seek reimbursement from their insurance company.

Name of policy holder:_____ID#_____

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CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and Disclosure of your Protected Health Information
Your protected health information will be used by Dallas Surgical Specialist or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day to day health care operations of the practice.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this contract.

Requesting a Restriction on the use or disclosure of your information
You may request a restriction on the use or disclosure of your protected information.

Dallas Surgical Specialist may or may not agree to restrict the use or disclosure of your protected health information.

If Dallas Surgical Specialist agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the consent is received will not be
affected.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
Dallas Surgical Specialist serves the right to modify the privacy practices outlined in this notice.

Authorization to Receive and Release Medical Records
I _____ hereby authorize for Dallas Surgical Specialist to receive and release any medical records for my proper health care treatment.

Signature
I have reviewed this consent form and give my permission to Dallas Surgical Specialist to use and disclose my health information in accordance with it.

Print Name of Patient:_____

Signature of Patient: _____Date_____

Witness:_____Date:_____

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PATIENT MEDICAL HISTORY

Name:_____

Please list all medication(s) you are currently taking (include non-prescription medication)
(Please include any vitamins, herbs and / or appetite suppressants.)
If additional space is needed we will provide an additional page for your convenience.

Medication and Dosage #Times per Day	**Medication and Dosage #Times per Day**
_____	_____
_____	_____
_____	_____

Please list all allergies (including medications, shellfish, iodine, tape, latex, etc.)

Medication	**Reaction**
_____	_____
_____	_____
_____	_____

Do you have any Physical Limitations? Yes/No Explain:_____
_____

Have you ever had a blood transfusion? Yes/No When? _____ **Reaction? Yes/No**

Please circle any of the following surgeries you have had and indicate date of surgery:

Tonsils_____	**Eye Cataract**_____	**Ear**_____
Carotid(neck artery)_____	**Lung**_____	**Back**_____
Heart: Bypass/Valve_____	**Colon**_____	**Colon**_____
Liver_____	**Spleen**_____	**Appendix**_____
Aneurysm_____	**Skin Cancers**_____	**Burns**_____
Hernia_____	**Others**_____	

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Have you ever Been Hospitalized for any reason besides surgery? Yes/No

Reason: _____

_____

Review of Systems

Please Circle any of the Following Medical Problems you now have or have had in the past:

General

Tuberculosis
High Blood Pressure
Polio
Stroke
Cataracts
Glaucoma
Gallstones
Diabetes
HIV/AIDS
Hiatal Hernia
Bleeding Problem
Rheumatic Fever
Leg cramps
Kidney Failure
Kidney Stones
Thyroid Problems
Head Injury
Blindness
Arthritis
Depression
Alcohol / Drug Abuse
Cancer :Type_____
Angina Shortness of Breath:_____ at rest ___ with Exertion

Pulmonary

Emphysema
Pneumonia
Asthma
Blood clot in lung
Sleep apnea
Wheezing

Cardiac

Heart Attack
Coronary Artery Disease
Blood Clot in Vein
Heart Valve Disease
Blood clot in artery

GASTRO INTESTINAL

Hepatitis
Peptic Ulcer

Do you wear glasses? Yes/No Reason: Reading Near-Sightedness/Far-Sightedness/other

Do any of your blood relatives(mother, father, sister, brother, child, and grandparent) have any of the following conditions? (circle all that apply)

High Blood Pressure
Heart Disease/Attack
Epilepsy
Arthritis
Glaucoma
Stroke
Gout
Blood Disorders
Kidney Failure
Tuberculosis
Asthma
Mental Disorders
Heart Valve Disease
Diabetes
Thyroid Disease

Cancer: Type_____
Usual Diet _____
Do you drink Alcohol? Yes/No Beer/Wine/ Hard Liquor # of 8oz glasses per day _____
Do you now or have you ever smoked? Yes/No # of packs per day_____#of years____
Do you use illicit drugs or abuse prescription medicines? Yes/No Type___ How often?
Do you Exercise? Yes/NO # times per week_____#minutes each time_____

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Number of Children_____Health Status: Well/Chronic illness Number Deceased_____
Parents: Mother: Living/Deceased-Age:_____ Father: Living/Deceased - Age:_____
Cause of death (if known):_____
Number of Brothers and sisters:_____ Health Status: Well/Chronic illness/Deceased(#___)
Pregnant?____Yes ____No Last Menstrual Cycle? _____

REVIEW OF SYSTEMS:

The following questions relate to health problems you have or have had in the past. Please **Circle** the appropriate conditions.

1. General: Weight Loss, Weight Gain, Fatigue
2. Neurological: seizures, vertigo, previous stroke, aneurysm, hearing impairment, abnormal speech, abnormal gait, double vision, other.
3. Ophthalmologic: glaucoma, cataracts, visual impairment, other
4. Ear, Nose, Throat: snoring, hearing aids, sinus, hoarseness, nose bleeds
5. Cardiac: Ankle swelling, chest pain, dizziness, shortness of breath leg pain, palpitations, other
6. Respiratory: Coughing, shortness of breath, wheezing, other
7. Gastrointestinal: bloody or black stools, change in bowel habits, hiatal hernia, reflux esophagitis, esophageal disease, ulcers, gastritis, duodenitis, hepatitis, yellow Jaundice, other liver disease, gallstones, gallbladder disease, pancreatic disease, chronic constipation, diarrhea, diverticulosis, diverticulitis, GI bleed, Chron's, ulcerative colitis, irritable bowel, other intestinal disease
8. Endocrine/Hormonal: thyroid disease, adrenal disease, goiter, other
9. Musculoskeletal: joint pain, arthritis, muscle, weakness, fibromyalgia, fracture, gout, cramping
10. Renal/urological: prostrate disease, frequent bladder infections, impotence, hematuria, hesitary, incontinence, nocturia>1
11. Skin: psoriasis, eczema, petichiae, pigmentation, hair loss, foot ulcers, lesions, lumps, rashes, nail changes
12. Immunological: gout, rheumatoid arthritis, lupus, other
13. Infections: AIDS, hepatitis, TB, syphilis, endocarditic, other
14. Hematologic: anemia, bleeding problem, clotting problem, leukemia, other
15. Psychological: depression, anxiety, panic attacks, anorexia, bulimia, other
16. Physical disability: problems with walking, other
17. Vascular; varicose veins, aortic aneurysm
18. Malignancy: cancer, tumor, lymphoma
19. Miscellaneous: osteoporosis, congenital syndrome, Marfan's, Turner's

I have reviewed the above information with the patient._____(M.D./MA)

Patient health history has been reviewed by _____ On _____.
Dallas Surgical Specialist Physician Date