OFFICE VISIT INFORMATION
New Patient Questionnaire
This Questionnaire is Part of the H&P/Consult

Amarillo Surgical Group Doctor: ___________________________________ Date: ______________

Patient's Information:
Name: Last ________________________ First ____________________ Middle __________________

Social Security #: ________________ Date of Birth: _________________ Age _______________

Gender: Male / Female Marital Status: Single / Married / Divorced / Widowed

Mailing Address:__________________________________ City: __________ ST: ____ ZIP: ______

Phone #'s: Home: __________________ Work: __________________ Other: _________________

E-mail Address: ____

Additional Party to Contact:
Name: Last ______________________ First ____________________ Middle _________________

Phone #'s: Home: ________________ Work: _________________ Other: __________________

Relationship to patient: ____

Responsible Party's Information (if different from patient):
Name: Last ______________________ First ____________________ Middle __________________

Social Security #: __________________ Date of Birth: _________________ Age ____________

Address:_____________________________________ City: __________ ST: ____ ZIP: _______

Phone #'s: Home: ________________ Work: _________________ Other: __________________

Employer: ____________________________ Relationship to Patient:________________________

Other Physicians:
Did another physician refer you to our office? Name: _____________________________________

Who is your primary / family physician? Name: ____

Is there another physician to whom we should send records pertaining to your visit?

____

Workman's Compensation
If your illness is related to an on the job injury, please complete an insurance information form.

Consent to Release Information
I authorize the release of any medical information necessary to process a claim on my behalf and request payment of any insurance benefits to BSA Amarillo Surgical Group or myself. I consent for BSA Medical Group to obtain my medication prescription history and place my prescription orders through the electronic prescribing system.

X____ DATE: ____________________
Signature of patient or guardian

____
Printed Name

1. **Why are you being seen in this office? ____**

2. **List any medications that you are currently taking (or attach your own list): If you are being seen in the hospital, list medications taken prior to admission. Please include over-the-counter medications (such as aspirin) as well as prescription drugs. Also include vitamins, minerals, or herbal supplements such as ginseng.**

Name of Medication:	Size of Dosage:	Frequency of Dosage (ie: twice a day):

3. **Are you allergic to any medications? YES / NO**

   If yes, please list the medication and your reaction to the medication below:

Allergy:	Reaction:

4. **List any other medical problems and/or previous illnesses such as diabetes, high blood pressure, stroke, etc.:**

____

____

5. **List any previous major injuries:**

Type of Injury:	Institution Where Treated:	Date of Injury:

6. **List any previous operations/surgeries:**

Type of Operation/Surgery:	Institution Where Performed:	Date of Operation:

7. **List any diagnostic tests you may have had related to your current condition (for example: echocardiogram, cardiac catheterization, CT scan, biopsy, etc.):**

Type of Test:	Institution Where Performed:	Date of Test:

FEMALE HISTORY (IF APPLICABLE)

8. **At what age did you first begin to menstruate?** ____
9. **Have you stopped menstruating?** circle one: **YES / NO**
10. **At what age were you when you had your first full-term pregnancy?** _____________________
11. **Do you still have regular periods?** circle one: **YES / NO**
    - **If no, at what age did you stop menstruating?** ___________________________________
12. **Do you take female hormones?** circle one: **YES / NO**

13. Do you have any family members with breast cancer? YES / NO

- If YES: circle one: MATERNAL / PATERNAL Age at Diagnosis: ________________

14. Do you have any family members with ovarian cancer? YES / NO

- If YES: circle one: MATERNAL / PATERNAL Age at Diagnosis: ________________

15. Complete the chart below with family history:

Relationship	**Age** (If Living)	**Age** (At Death)	Stroke	Diabetes	Hypertension	Heart Disease	Tuberculosis	Alcoholism	Jaundice	Bleeder	Obesity	Gout	Asthma	Cancer	Mental Illness		
Father																	
Mother																	

List siblings, children, and other relatives below

Relationship	**Age** (If Living)	**Age** (At Death)	Stroke	Diabetes	Hypertension	Heart Disease	Tuberculosis	Alcoholism	Jaundice	Bleeder	Obesity	Gout	Asthma	Cancer	Mental Illness		

16. Have you ever used tobacco? YES / NO

- Circle ALL that apply: Cigarettes | Cigar | Pipe | Chewing/Snuff | Smokeless
- How much per day? ____
- Number of years used? _____ Ever tried to quit? ______ Year quit? ____________

17. Are you exposed to passive smoke? (i.e.: smoker in the home) _____________________

18. Do you drink alcohol? YES | NO

- If Yes: type of alcohol: ____
- Amount: ____
- How often: daily, weekly, socially, occasionally, rarely (circle one)

19. **Do you drink caffeine?** YES | NO **How often?** _____ Circle ALL that apply: Coffee | Tea | Soda
20. **What is your highest level of education?** Grade Level ____ High School College Post Graduate
21. **What is your occupation?** ____
22. **Employer:** ____
23. **Do you exercise regularly?** YES | NO
    - Type of Exercise: ____
24. **Do you follow a special diet?** YES | NO
    - Please Describe: ____
25. List other persons living in your home and their relationship to you.

Name:	Relationship to you:

REVIEW OF SYSTEMS

CONSTITUTIONAL
N Y Chills
N Y Fatigue
N Y Fever
N Y Night Sweats
N Y Weight Gain
N Y Weight Loss

HEAD / EYES / EARS / THROAT
N Y Hearing Loss
N Y Sore Throat
N Y Visual Changes

RESPIRATORY
N Y Chronic Cough
N Y Cough
N Y Known TB Exposure
N Y Shortness of Breath
N Y Wheezing

CARDIOVASCULAR
N Y Chest Pain
N Y Claudication (Leg Cramps)
N Y Palpitations
N Y Edema (Swelling of feet, ankles or legs)
N Y Dyspnea (shortness of breath with exertion)
N Y Orthopnea (Difficulty breathing when lying flat)

VASCULAR
N Y DVT (Blood clots in legs)
N Y Phlebitis (Varicose Veins)

GASTROINTESTINAL
N Y Abdominal Pain
N Y Blood in Stools
N Y Change in Stools
N Y Constipation
N Y Diarrhea
N Y Heartburn
N Y Loss of Appetite
N Y Nausea
N Y Vomiting

REPRODUCTIVE (FEMALE ONLY)
N Y Breast Discharge
N Y Breast Lump
N Y Irregular Menses

GENITOURINARY
N Y Dysuria (Difficulty Urinating)
N Y Hematuria (Blood in Urine)
N Y Frequent Urination
N Y Urinary Incontinence
N Y Urinary Retention
N Y Nocturia (Awakening to Urinate)

METABOLIC/ENDOCRINE
N Y Brittle Nails
N Y Cold Intolerance
N Y Hair Changes
N Y Heat Intolerance
N Y Polydipsia (Excessive Thirst)

NEUROLOGICAL
N Y Extremity Numbness
N Y Extremity Weakness
N Y Headache
N Y Memory Loss
N Y Seizures
N Y Tremors

PSYCHIATRIC
N Y Anxiety
N Y Depression
N Y Insomnia

INTEGUMENTARY
N Y Hives
N Y Itching
N Y Mole Changes
N Y Rash
N Y Skin Lesion

MUSCULOSKELETAL
N Y Back Pain
N Y Joint Pain
N Y Muscle Weakness
N Y Neck Pain

HEMATOLOGIC/LYMPHATIC
N Y Easy Bleeding
N Y Easy Bruising
N Y Lymphadenopathy (Swollen glands)

IMMUNOLOGIC
N Y Food Allergies
N Y Seasonal Allergies

Acknowledgement of Review of Notice of Privacy Practice

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

(Optional)
I also give my authorization for my personal health information to be shared with family member(s) and other designated person(s) listed below if they request with or are present when discussions occur. This authorization may be revoked, limited in writing and will be documented in my medical record.

Name	Relation to Patient	Phone #
Name	Relation to Patient	Phone #
Name	Relation to Patient	Phone #

____
Signature of Patient or Personal Representative

____
Date

____
Name of Patient or Personal Representative

____
Description of Personal Representative's Authority

INSURANCE INFORMATION

THIS FORM MUST BE COMPLETED
IN ORDER FOR US TO FILE YOUR INSURANCE

We need the following information for precertification of services and to file your insurance claim correctly. **The information may not be on your insurance card.**

Which Insurance Pays First?

PRIMARY Insurance: ____

Policyholder's name: ____

Policyholders Social Security Number: ______________________________

Policyholder's place of work: _____________________________________

Policyholder's date of birth: ______________________________________

Which Insurance Pays Second?

SECONDARY Insurance: ____

Policyholder's name: ____

Policyholders Social Security Number: ______________________________

Policyholder's place of work: _____________________________________

Policyholder's date of birth: ______________________________________

BSA – Amarillo Surgical Group
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INFORMATION CONCERNING PAYMENT FOR YOUR MEDICAL CARE

As a service to our patients, BSA Amarillo Surgical Group is happy to file claims for your medical care directly to your insurance company. Please supply our office with all the information necessary to submit your claim. We must have complete information to file your claim. You should first verify that a copy of your current health insurance identification card is on file with our office. You will be provided an "Estimate of Fees" and asked to pay the portion of fees considered "Patient Responsibility". Patient Responsibility is generally those fees not expected to be paid by your insurance carrier.

We are providers for many area PPOs, HMOs and Network programs. If you have chosen our practice for your care and you are aware that our physicians are not members of your network, we will ask that you complete an "out-of-network waiver" form. Some insurance companies greatly reduce payment for medical services if a patient goes out-of-network".

If you do not have health insurance, you will be asked to pay fees or reach an acceptable financial arrangement prior to services being rendered. We may also provide information for financial assistance, should you require this service.

PATIENT FINANCIAL RESPONSIBILITY

I agree to be responsible for payment of my medical care or the medical care for the below mentioned patient. I also assign to my physician(s) my right to all applicable insurance benefits and my cause of action against any third party responsible or liable for the condition or injuries requiring physician services.

Patient Name ____

Signed ______________________________ Date ____________________

(patient or guardian)

For Office Use Only

Witnessed ______________________________ Date ____________________

(BSA-ASG Employee)