

## PATIENT INFORMATION

Full Name \_\_\_\_\_ Date \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Soc. Sec# \_\_\_\_\_ Cell \_\_\_\_\_

Email Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_ Relation: \_\_\_\_\_

Name of Primary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name of Secondary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**PRIMARY CARE PHYSICIAN** \_\_\_\_\_

**REASON FOR REFERRAL** \_\_\_\_\_

**NAME AND PHONE NUMBER OF YOUR PREFERRED PHARMACY**

\_\_\_\_\_

The categories for race and ethnicity are based on standards published in the Federal Register and are MANDATED BY MEDICARE/MEDICAID "Meaningful use" Rule. This is very similar to the information you may have reported in the US Census Survey. We understand that you may feel these categories do not apply to you, or may not be reflective of how you identify yourself, but we are required to follow these regulations without exceptions.

**Gender:**  Male  Female

**Race:**  American Indian  Asian/Pacific Islander  African American  Caucasian  Other  Refuse to report

**Ethnicity:**  Hispanic  Non-Hispanic  Unknown  Refuse to Report

**Language Preference:**  English  Other  Please Specify if not English \_\_\_\_\_

**Marital status:**  Single  Married  Divorced  Widowed Number of Children \_\_\_\_\_

\_\_\_\_\_

### HENDERSONVILLE

353 New Shackle Island Road | Suite 241C  
Hendersonville, TN 37075  
615.264.5850 | fax 615.264.5884

## MEDICAL INFORMATION

**PAST MEDICAL HISTORY:** Please list any medical problems you may have:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_

**SURGICAL/TRAUMA HISTORY:** List the operations or injuries you have had, along with month, year, and hospital:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_

**MEDICATION LISTING:** List ALL CURRENT MEDICATIONS & DOSAGE:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_

**List ALL MEDICATION ALLERGIES:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

Are you allergic to LATEX, SHELLFISH, or IODINE?  YES  NO

Please CHECK if you have taken the following in the last month:  Prednisone  Coumadin  Aspirin/Motrin/Naproxen

ARE YOU ACTIVELY IN A PAIN MANAGEMENT PROGRAM?  YES  NO

---

### HENDERSONVILLE

353 New Shackle Island Road | Suite 241C  
Hendersonville, TN 37075  
615.264.5850 | fax 615.264.5884

## PATIENT INFORMATION

**REVIEW OF SYMPTOMS:** Place an "X" in the box for **ALL SYMPTOMS** below you have experienced recently.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Fevers                | <input type="checkbox"/> Short of breath       | <input type="checkbox"/> Upper abdomen pain |
| <input type="checkbox"/> Night Sweats          | <input type="checkbox"/> Irregular pulse       | <input type="checkbox"/> Lower abdomen pain |
| <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Cough                 | <input type="checkbox"/> Jaundice           |
| <input type="checkbox"/> Weight                | <input type="checkbox"/> Diarrhea              | <input type="checkbox"/> Painful urination  |
| <input type="checkbox"/> Gain _____ lbs        | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Blood in urine     |
| <input type="checkbox"/> Loss _____ lbs        | <input type="checkbox"/> Bloody stools         | <input type="checkbox"/> Kidney stones      |
| <input type="checkbox"/> Wear glasses/contacts | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Joint/muscle pain  |
| <input type="checkbox"/> Hearing loss          | <input type="checkbox"/> Heartburn             | <input type="checkbox"/> Joint swelling     |
| <input type="checkbox"/> Ankle swelling        | <input type="checkbox"/> Nausea                | <input type="checkbox"/> Skin rash          |
| <input type="checkbox"/> Bloody nose           | <input type="checkbox"/> Muscle weakness       | <input type="checkbox"/> Mole changes       |
| <input type="checkbox"/> Nasal discharge       | <input type="checkbox"/> Swollen lymph nodes   | <input type="checkbox"/> Breast lump/pain   |
| <input type="checkbox"/> Hoarseness            | <input type="checkbox"/> Vomiting              | <input type="checkbox"/> Dizziness          |
| <input type="checkbox"/> Chest pain            | <input type="checkbox"/> Vomiting blood        | <input type="checkbox"/> Seizures           |
| <input type="checkbox"/> Calf pain             | <input type="checkbox"/> Anxiety               | <input type="checkbox"/> Depression         |
| <input type="checkbox"/> Numbness/tingling     | <input type="checkbox"/> Easy bruising         | <input type="checkbox"/> Bleeding tendency  |
| <input type="checkbox"/> Excessive hair growth |  |   |

**SOCIAL HISTORY:**

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Do you perform any heavy lifting on a daily basis? Yes  No

Do you smoke? Yes  No  How many packs per day? \_\_\_\_\_ Quit smoking? \_\_\_\_\_

Other tobacco use (chewing tobacco, cigars, pipe, e-cigarettes) : \_\_\_\_\_

Drug use? Yes  No

Please describe your alcohol intake:  None  Occasional  1-2 Drinks a day  >2 drinks a day

**FAMILY HISTORY:** Please mark (M) for Mother and (F) for Father next to the item if you have first degree relatives with the following cancers or diseases:

\_\_\_\_\_ Heart disease \_\_\_\_\_ Stroke \_\_\_\_\_ Aneurysm \_\_\_\_\_ High blood pressure \_\_\_\_\_ Diabetes Mellitus

\_\_\_\_\_ Cancer If cancer what type \_\_\_\_\_

**HENDERSONVILLE**

353 New Shackle Island Road | Suite 241C  
Hendersonville, TN 37075  
615.264.5850 | fax 615.264.5884

## PATIENT CONSENT FORM

I, the undersigned, hereby consent to the following:

- I fully understand that this is given in advance of any specific diagnosis or treatment.
- I intend this consent to be continued in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.
- I, the undersigned, acknowledge that Advanced Surgical Associates will use and disclose my information for the purpose of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.
- **TREATMENT** includes, but is not limited to: the administration and performance of all treatments: the administration of any needed anesthetics, the use of prescribed medication, the performance of procedures may be deemed necessary or advisable in the treatment of this patient, the taking and utilization of cultures and/or other medically accepted tests, all of which in the judgment of the attending physician are considered medically necessary.
- **PAYMENT** I hereby authorize payment for services I received from Advanced Surgical Associates to be made directly to Advanced Surgical Associates. I acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided. I am financially responsible for charges not covered including, but not limited to co-insurance, co-payments, and deductibles. I acknowledge that I am also responsible for collection fees, court costs, attorney fees, any other fees incurred by the collection agency or Advanced Surgical Associates physicians may discontinue care for any patient due to non-payment or accounts sent to collections. I understand it is policy of Advanced Surgical Associates to receive payment before or upon appointment for a patient without insurance/self-pay.
- **REFERRALS** I understand that all patients having insurance requiring a referral for surgery services will be required to present the referral before services are provided. Any patient seeking service without a referral must pay for the service in advance or reschedule the appointment.
- A photocopy of this consent shall be considered as valid as the original. This authorization applies to all occasions of service until it is revoked.

---

Patient Signature/Guardian

---

Date

### HIPAA NOTICE OF PRIVACY PRACTICES

There is a copy of the HIPAA Notice of Privacy Practices located in the waiting room.

- I have received my copy of the Note of Privacy Practices
- I have been offered a copy of the Notice of Privacy Practices and declined.

---

Patient Signature

---

Date

---

### HENDERSONVILLE

353 New Shackle Island Road | Suite 241C  
Hendersonville, TN 37075  
615.264.5850 | fax 615.264.5884

## PAIN MEDICATION POLICY

Our primary FOCUS is to reduce your pain to a tolerable level over the short term (approximately two weeks)

The GOAL with this policy is to:

- (1) Educate patients that complete resolution of pain is not always possible.
- (2) And, to emphasize, as your surgeon, we assist with short term pain issues, not chronic pain.

Our patients should understand the following:

- No pain medication will be filled after hours.
- No pain medication will be refilled on the weekends.
- No pain medication will be refilled on holidays.
- If you need refills on pain medication please contact us during normal business hours.
- Advanced Surgical Associates, will not contribute or condone pain medication addiction or long-term usage.
- Per Tennessee State Law, controlled substances (such as Percocet, Norco, etc) can only be prescribed for post-operative pain for a duration of 3 days (or 3 day supply). **Refills will not be given.**

Thank you for your consideration in advance.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

---

### HENDERSONVILLE

353 New Shackle Island Road | Suite 241C  
Hendersonville, TN 37075  
615.264.5850 | fax 615.264.5884

## RELEASE OF MEDICAL INFORMATION

NAME *(Please print)*: \_\_\_\_\_ DOB: \_\_\_\_\_

By Signing Below, I Authorize Advanced Surgical Associates To Release My Medical And Billing Information To:

**RELATIONSHIP**

**NAME OF DESIGNATED PERSON**

SPOUSE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
CHILDREN	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
IN-LAWS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
CAREGIVERS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
PARENTS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
OTHERS	_____		

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**We ask that if you have any change in this request, that you please inform the receptionist.**

Advanced Surgical Associates may leave appointment information on my voicemail:

HOME	<input type="checkbox"/> YES	<input type="checkbox"/> NO
WORK	<input type="checkbox"/> YES	<input type="checkbox"/> NO
RELATIVE	<input type="checkbox"/> YES	<input type="checkbox"/> NO

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

I authorize the following to pick up prescriptions, X-rays, etc.

**RELATIONSHIP**

SPOUSE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
RELATIVE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
CAREGIVER	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**We charge a \$20 flat rate for 1-5 pages plus .50 per additional page and postage.**

I understand that Advanced Surgical Associates will ask for identification of the person picking up patient medical information or products.