ADVANCED SURGICAL ASSOCIATES

AdvancedHEALTH

www.theadvancedsurgicalassociates.com

THOMAS B. TAYLOR JR. MD, FACS

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 _____

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MEDICAL INFORMATION

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

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

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

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

MEDICATION LISTING: List ALL CURRENT MEDICATIONS & DOSAGE:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

List ALL MEDICATION ALLERGIES:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 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

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

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

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 _____

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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 CLINIC
353 New Shackle Island Road | Suite 247C
Hendersonville, TN 37075
615.264.5850 | fax 615.264.5884

MACON COUNTY CLINIC
205 Medical Drive
Lafayette, TN 37083
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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 _____

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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	☐ YES	☐ NO	_____
CHILDREN	☐ YES	☐ NO	_____
IN-LAWS	☐ YES	☐ NO	_____
CAREGIVERS	☐ YES	☐ NO	_____
PARENTS	☐ YES	☐ 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	☐ YES	☐ NO
WORK	☐ YES	☐ NO
RELATIVE	☐ YES	☐ NO

PATIENT SIGNATURE _____ DATE _____

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

RELATIONSHIP			
SPOUSE	☐ YES	☐ NO	_____
RELATIVE	☐ YES	☐ NO	_____
CAREGIVER	☐ YES	☐ 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.

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