*For office staff use only: ROOM # _____

Temp: _____ HR: _____ BP: _____ HT: _____ WT: _____

NEW PATIENT MEDICAL INFORMATION SURVEY

Today's Date: _____ **Augusta Surgical Group**

We are glad you chose the Augusta Surgical Group to meet your surgical needs. Please take a few minutes to fill out this form, as it will help us provide you with optimal care .Please circle choices or fill in blanks where appropriate. Thank you for your time.

Name: _____ **Date of Birth:** _____ **Sex: M / F** **Age:** _____

Social history: Occupation _____ **Married / Single / Divorced / Widowed**

Primary Medical Doctor: _____ **Referring Doctor:** _____

Cardiologist: _____ **Nephrologist:** _____ **Dialysis Center:** _____ **Days you dialyze:** _____

Other Doctors & their specialties: _____

What medical concern brings you to the office today? _____

Allergies: (drug, food, tape, latex). **What is your reaction?** _____

Have you recently been exposed/treated for bed bugs/scabies/lice? _____

List Medications that you are taking:

1._____ **4.**_____ **7.**_____ **10.**_____

2._____ **5.**_____ **8.**_____ **11.**_____

3._____ **6.**_____ **9.**_____ **12.**_____

Date of: **Recent Mammo:** _____ **Colonoscopy:** _____ **Hospitalizations:** _____ **X-rays/Scans:** _____

Surgeries (PLEASE CIRCLE): Cardiac Surgeries: (stents, pacemaker, valve replacement, ablation, transplant), Previous Hernia Repairs (what type): _____, Gallbladder, Bowel Surgery, Appendix, Weight Loss Surgery
Other: _____

Medical Conditions (PLEASE CIRCLE): Arthritis, Asthma, COPD, Bleeding Disorders/Blood Clots, Cancer (what type): _____, Stroke, Diabetes, GERD, Hepatitis, HIV/AIDS, Heart Disease, High Cholesterol, High Blood Pressure, MRSA, Kidney Disease, Seizures, Thyroid Disease, **Other:** _____

Family Medical History: (List medical conditions affecting your immediate family)
Mother- ALIVE - DECEASED Father- ALIVE - DECEASED Other

Tobacco: Current Smoker YES or NO, Packs Per day_____ Former Smoker: Years quit _____
Years Smoked: _____ Alcohol YES or NO Type: _____ Amount per Week: _____
Other recreational drugs: _____

Obstetrical/gynecologic history: Last menstrual period: _____ Age at first childbirth: _____ Age at first period: _____
Are you pregnant: ____ Number of deliveries: _____ Number of pregnancies: _____
Have you had natural menopause/hysterectomy/still menstruating (circle one).

Personal / Religious preferences that you would like us to consider or that may impact your care_____

Do you CURRENTLY or have you RECENTLY had any of the conditions listed below?
Please circle N for NO or Y for YES

Constitutional

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

Skin

Rash	N	Y
Wounds	N	Y
Lesions	N	Y
Jaundice	N	Y

ENT

Hearing Loss	N	Y
Congestion	N	Y
Sore Throat	N	Y
Nosebleeds	N	Y
Choking	N	Y

Eyes

Visual Impairment	N	Y
Eye Pain	N	Y

Cardiovascular

Chest Pain	N	Y
Irregular Heartbeat	N	Y
Leg Swelling	N	Y

Respiratory

Coughing	N	Y
Shortness of Breath	N	Y
Wheezing	N	Y
Sleep Apnea	N	Y
Chest Tightness	N	Y

Gastrointestinal

Heartburn	N	Y
Acid Reflux	N	Y
Nausea	N	Y
Vomiting	N	Y
Abdominal Pain	N	Y
Diarrhea	N	Y
Constipation	N	Y
Blood in Stool	N	Y

Genitourinary

Painful Urination	N	Y
Urgency	N	Y
Frequency	N	Y
Blood in Urine	N	Y
Difficulty Urinating	N	Y
Pelvic Pain	N	Y

Musculoskeletal

Muscle pain	N	Y
Back Pain	N	Y
Joint Pain	N	Y

Hematologic

Bruises easily	N	Y
Bleeds easily	N	Y

Neurological

Headaches	N	Y
Dizziness	N	Y
Numbness	N	Y
Weakness	N	Y
Seizures	N	Y
Speech Difficulty	N	Y

Psychiatric

Depression	N	Y
Substance Abuse	N	Y
Nervousness Anxiety	N	Y
Memory Loss	N	Y
Suicidal Thoughts	N	Y

***For office staff use only:**

History:

A/P:

PE:

Augusta Surgical Group, P.C.
New Patient Information

Name: _____ SSN: _____ DOB: _____ Male / Female

Address_____ City: _____ ST: _____ Zip: _____

Home #._____ Work #: _____ Cell: _____

Primary Number I wished to be contacted on. HOME / WORK / CELL (CIRCLE) Email: _____

Need Interpreter? YES or NO Primary Language _____ Marital Status M S W D

Ethnicity_____ Religion _____ Race _____

Referring Doctor_____ Primary Care Doctor_____

Preferred Pharmacy Name and Location: _____ Preferred Laboratory: _____

PATIENT EMPLOYMENT INFORMATON

Employer _____

Employment Status _____ Employer Phone No: _____

Guarantor of Account: SELF / OTHER Relationship: _____ Phone No:_____

Address_____ City: _____ ST: _____ Zip: _____

PRIMARY INSURANCE:

Insurance Company: _____ ID: _____ SSN: _____

Group No: _____ **Subscriber: Self / Spouse/ Parent / Other** Relationship: _____

Subscriber Name:_____ Subscriber DOB:_____

Subscriber Employment information_____

SECONDARY INSURANCE:

Insurance Company: _____ ID: _____ SSN: _____

Group No: _____ **Subscriber: Self / Spouse / Parent / Other** Relationship: _____

Subscriber Name:_____ Subscriber DOB:_____

Subscriber Employment information_____

All Information given is accurate. I give my permission for Augusta Surgical Group (ASG) to contact me regarding practice information by the above methods.

Print Name: _____ **Signature:** _____ **Date:** _____

AUGUSTA SURGICAL GROUP
1430 B HARPER STREET
AUGUSTA, GA 30901

IMPORTANT MESSAGE TO OUR PATIENTS

Insurance Coverage and reimbursement is a very confusing issue. We would like to help clarify some of the most common misconceptions so that you, the patient, will understand what is expected of your insurance companies and you regarding visits to our office and subsequent procedures performed here or at the hospital.

Most Insurance policies pay for office visits and surgical procedures (or operations). We will file a claim to your insurance company for any procedures. They will pay a percentage (after you have met your deductibles) of the fee, and unless you have a secondary insurance, you will be responsible for the remaining portion of the fee. You will be asked to pay your office visit co-payment before you are seen. If you do not have a co-payment, we will check on your insurance to see what you will owe.

SELF PAY patients must pay at the time of the visit. If surgery is needed, we will have our patient accounts representative discuss this with you before surgery.

MEDICARE operates by a different set of rules. Since your physicians participate in the Medicare program, we are required to file for all services provided to you. Medicare allows a specific fee for each visit or procedure and pays 80% of this allowance. We are then required to bill you for the additional 20% (through either supplemental insurance or your payment) and we are required to write off the difference between our normal fee and the fee Medicare allows. The new Medicare Advantage plans operate mainly with a co-pay and/or coinsurance. This may not apply if we do not participate in your particular Medicare Advantage Plan.

Each Insurance Company is unique so we need as much information as possible about your present coverage. Many companies are now requiring precertification or preauthorization before they will allow any charges.

Please help us help you by providing our staff as much detail as you have regarding your insurance coverage. Remember you the patient, are responsible for charges incurred through our office, regardless of insurance coverage.

PATIENT SIGNATURE: _____ **DATE:** _____

AUGUSTA SURGICAL GROUP, P.C

PLEASE READ AND SIGN BELOW

Your signature below indicates your consent for treatments, and hereby authorizes the release of any information acquired in the course of your examination or treatments to your insurance company.

Signature:_____ **Date:** _____

I hereby assign, transfer, convey and authorize all payments to the physicians for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.

Signature:_____**Date:**_____

Privacy practices acknowledgment: I hereby, acknowledge that Augusta Surgical Group, P.C. will provided me with the notice of its privacy practices as required by the federal health insurance portability and accountability act of 1996 (HIPAA). I understand that Augusta Surgical Group, P.C. , upon my request, will provide me with a copy of the notice of privacy practices.

Signature:_____**Date:**_____

1430 Harper Street, Building B, Augusta, GA 30901 Phone: (706) 724-5451 and Fax: (706) 724-9562

Augusta Surgical Group, P.C.

Patients Medical Approval List

Date: _____

Patients Name: _____

Please List anyone below that we may discuss your medical information with. If their name is not on this list, we cannot disclose any of your medical information.

Emergency Contact Name and hipaa list below

Name:_____ Relationship:_____Phone NO:_____

Name: _____ Relationship: _____ Phone No: _____

Name: _____ Relationship: _____ Phone No: _____

Name: _____ Relationship: _____ Phone No: _____

Signature: _____