Riverside Surgical Associates

General Surgery Patients

Patient's Name: ______________________________________Date: ____/_____/_____
Primary Care Physician:________________Referring Physician:____________________
Patient's Age:_________Patient's Occupation:__________________________________
Reason for today's visit:____

Have you ever had any of the following?

	Yes	No		Yes	No		Yes	No
Anemia	___	___	Cancer	___	___	Heart Attack	___	___
High Blood Pressure	___	___	Stroke	___	___	Asthma	___	___
Emphysema	___	___	Pneumonia	___	___	Diabetes	___	___
Stomach Ulcers	___	___	Colitis	___	___	Constipation	___	___
Change in Bowels	___	___	Jaundice	___	___	Hernias	___	___
Thyroid problems	___	___	Seizures	___	___	Back pain	___	___
Arthritis	___	___	Blood clots	___	___	Kidney disease	___	___
MRSA infections	___	___	Fractures	___	___	Other	___	___

Have you ever had surgery?

	Yes	No		Yes	No		Yes	No
Hernia repair	___	___	Gallbladder	___	___	Hemorrhoids	___	___
Breast Surgery	___	___	Appendectomy	___	___	Colon Surgery	___	___
Stomach	___	___	Heart	___	___	Colonoscopy	___	___
Hysterectomy	___	___	Cancer Operation	___	___ What Kind? ______________________			

Other: ____

Medications taken on a daily basis:

Medication Name	Dose	Reason for Medication	See Medication List ______
______________________	__________	__________________	
______________________	__________	__________________	
______________________	__________	__________________	
______________________	__________	__________________	
______________________	__________	__________________	
______________________	__________	__________________	
______________________	__________	__________________	
______________________	__________	__________________	

Do You Take: Aspirin_________Lovenox_________Coumadin_________Plavix________Prednisone__________
What Dose?____

Do You Smoke? __________ How Much?__________________ When did you quit?_____________
Do You Drink? __________ How Much? ____
Do You Do Drugs?_________What Kind?____

Has any blood relative had:

	Yes	No	Relationship		Yes	No	Relationship
Cancer	___	___	___________	Thyroid Problems	___	___	_______________
Breast Disease	___	___	___________				

Allergies to Medications:

	Yes	No		Yes	No		Yes	No
Penicillin	___	___	Latex	___	___	Sulfa Drugs	___	___
Iodine	___	___	Shell Fish	___	___`	Other_____________	___	___

Patient Registration Form

Patient Information

Patient Last Name____________________ First Name________________DOB_____/_____/_____

Address____Home Phone #_________________

City_____________________State ______ Zip code_________ Cell #__________________

Email address: ____

Sex Male__ Female __ Single__ Married __ Widowed__ Divorced__ SS#_____-______-______

Patient's Employer________________________________ Business Phone # _________________

Business Address________________________________ City_________State_______Zip________

Emergency Contact _____________________________________Phone #___________________

Primary Insurance

Person responsible for account: Last Name__________________ First Name__________________

DOB_____/_____/_____. SS#_____-_____-_____ Relation to patient__________________________

Address (if different)________________________City________________State_____Zip___________

Responsible party employed by____

Business Address__________________________City______________State_____Zip____________

Insurance Name _________________________________Insurance ID#_______________________

Insurance Group #____________________________Insurance Tel #_______________________

Secondary Insurance

Person responsible for account: Last Name__________________ First Name_________________

DOB_____/_____/_____. SS#_____-_____-_____ Relation to patient__________________________

Address (if different)________________________City________________State_____Zip___________

Responsible party employed by____

Business Address__________________________City______________State_____Zip____________

Insurance Name _________________________________Insurance ID#_______________________

Insurance Group #____________________________Insurance Tel #_______________________

CONSENT TO TREATMENT

I am presenting myself for examination and treatment at Riverside Surgical Associates and I voluntarily consent to the rendering of such care encompassing routine diagnostic procedures and medical treatment, by authorized agents and employees of the office, and by its medical staff, as may, in their professional judgment, be deemed necessary or beneficial. I further authorize electronic access of my pharmaceutical records, if applicable, for treatment purposes. I understand that my records will only be accessed by authorized individuals.
I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as the result of treatment or examination.

___________	______________________	______________________________	______________________
Date	Print Patient's Name	Signature of Patient or Responsible Person	Relationship to Patient

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FINANCIAL CONSENTS

Release of Information, Assignment of Benefits, Payment Guarantee

AUTHORIZATION TO RELEASE INFORMATION: Riverside Surgical Associates (RSA) is authorized to release to any insurance companies having coverage on me any information pertaining to the diagnosis and/or procedures relative to this treatment. A photostatic copy of this authorization shall be considered as effective and valid as the original.

ASSIGNMENT OF INSURANCE BENEFITS AND RIGHT OF RECOVERY: In consideration of services rendered, I hereby forever assign and give to RSA all rights, title and interest in the benefits payable for services rendered by RSA, provided by my policy(ies) of insurance. This transaction shall be for the recovery on said policy(ies) of insurance, it shall not be construed to be an obligation of RSA to pursue any such right of recovery. Provided however, this assignment and transfer shall not take away my standing to make claim or sue for benefits individually should coverage be denied by any insurance carrier(s). I hereby authorize the insurance company(ies) to pay directly to RSA all benefits due under said policy(ies) by reason of services rendered therein. I will pay RSA for all charges in excess of the sums actually paid pursuant to said policy(ies). A photostatic copy of this authorization shall be considered as effective and valid as the original.

_______________	______________________________	______________________________
Date	Patient or Parent if Minor	Insured Person

MEDICARE CERTIFICATION

Patient's Certification, Authorization to Release Information and Payment Request: I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize Riverside Surgical Association to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Riverside Surgical Associates on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. I further agree that I will furnish evidence along with the Medical Insurance Policy number(s) that said insurance plan payments have been exhausted or unavailable for payment prior to payment submission and anticipation of payment by Medicare. I understand that I am responsible for any health insurance deductibles and coinsurance.

____________________	____________________________________
Date	Patient's Signature

Acknowledgement of Receipt of Notice of Privacy Practices

This form accompanies the HIPAA Omnibus Notice of Privacy Practices from Riverside Surgical Associates. Please note that by signing the Acknowledgement form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

________________________	____
Date	Signature*
	____
	Print or Type Name

*As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

______________________________	____
Signature	Relationship
	____
	Date