Today's Date:

____/____/____

General Surgery Patients

Patient's Name: ________________________________Date of Birth: ____/_____/_____
Primary Care Physician:________________Referring Physician:_____________________
Patient's Age:_________Patient's Occupation:_____________________________________
Reason for today's visit:____

Have you ever had any of the following medical problems? (Please check all that apply.)

☐ Diabetes	☐ Thyroid problems	☐ Seizures	☐ Emphysema
☐ Anemia	☐ Arthritis	☐ Blood Clots	☐ High Cholesterol
☐ High Blood Pressure	☐ HIV	☐ Heart Attack	☐ Asthma
☐ Stomach Ulcers	☐ Stroke	☐ Kidney Disease	☐ MRSA

☐ Cancer, what kind ____

Are you currently experiencing? (Please check all that apply.)

☐ Jaundice	☐ Hernia	☐ Constipation	☐ Nausea/Vomiting
☐ Back Pain	☐ Diarrhea	☐ Rectal Bleeding	☐ Abdominal Pain

Have you ever had surgery? (Please check all that apply.) ☐ No Surgery

☐ Hernia repair	☐ Breast Surgery	☐ Colon Surgery	☐ Hysterectomy
☐ Gallbladder	☐ Appendectomy	☐ Orthopedic Surgery	☐ Heart Surgery

☐ Cancer Surgery, what kind____
☐ Have you had a colonoscopy? If so, when was your last one? ______________________________

Medications taken on a daily basis:

PLEASE PRINT CLEARLY

Medication Name	Dose	Reason for Medication	See Medication List ______
____________________________	_________	_________________	
____________________________	_________	_________________	
____________________________	_________	_________________	
____________________________	_________	_________________	
____________________________	_________	_________________	
____________________________	_________	_________________	
____________________________	_________	_________________	
____________________________	_________	_________________	

Do you take any blood thinners (i.e. aspirin, Lovenox, Coumadin, Plavix, Xarelto, Eliquis) ☐Yes ☐No

Do You Smoke? Yes No How Much?_____________________ When did you quit?_______________
Do You Drink? Yes No How Much? ____
Do You Do Drugs? Yes No What Kind?____

Has any blood relative had: PLEASE SPECIFY FATHER'S SIDE OR MOTHER'S SIDE

		Relationship			Relationship
Breast Disease	☐Yes ☐No	_________________________	Thyroid Problems	☐Yes ☐No	__________________
Diabetes	☐Yes ☐No	_________________________	High Blood Pressure	☐Yes ☐No	__________________
Heart Disease	☐Yes ☐No	_________________________	Cancer	☐Yes ☐No	Type: __________________

____

Are you allergic to any <u>medications</u>? ☐Yes ☐No

Penicillin	☐Yes ☐No	Sulfa Drugs	☐Yes ☐No	Latex	☐Yes ☐No
Iodine	☐Yes ☐No	Shellfish	☐Yes ☐No	Other	________________________

Patient Registration Form

Patient Information

Patient Last Name____________________ First Name________________ DOB_____/_____/_____

Address_______________________________________City_________ State_______ Zip _________

Home Phone:__________________ Cell:__________________ I prefer to be reached by ☐Cell ☐Home

Email address: ____

☐Male ☐Female ☐Single ☐Married ☐Widowed ☐Divorced

Emergency Contact ______________________________________Phone #___________________

Preferred Pharmacy ________________________ Address_______________________________

Is this is a work-related injury? ☐ Yes ☐ No

Primary Insurance

Insurance Name ________________________________ Insurance ID# ______________________

Insurance Group # ______________________________ Insurance Tel #______________________

Person responsible for account (if not the patient):

Last Name_______________________________ First Name_____________________________

DOB_____/_____/_____ Relation to patient ____

Address (if different) ________________________City______________State______ Zip_________

Secondary Insurance

Insurance Name ________________________________ Insurance ID# ______________________

Insurance Group # ______________________________ Insurance Tel #______________________

Person responsible for account (if not the patient):

Last Name_______________________________ First Name_____________________________

DOB_____/_____/_____ Relation to patient ____

Address (if different) ________________________City______________State______ Zip_________

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