SURGICAL SPECIALISTS OF SOUTHWEST FLORIDA, P.A. & SWFL VASCULAR CENTER

# New Patient Form

**Name:** _____ **DOB:** _____

****Please provide a brief explanation for today's visit:** _____

**Smoking Status:** ☐ Former ☐ Never a smoker ☐ Current smoker, Packs per day_____

**Have you had: Pneumonia Vaccine?** ☐ No ☐ Yes, when? _____ **Flu Vaccine?** ☐ No ☐ Yes, when? _____

**Review of Systems:** Do you have any of problems related to the following systems? Check the appropriate box.

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| **Fatigue** | ☐ | ☐ | **Abdominal Pain** | ☐ | ☐ |
| **Fever** | ☐ | ☐ | **Black or tarry stool** | ☐ | ☐ |
| **Chills** | ☐ | ☐ | **Bloody stool** | ☐ | ☐ |
| **Eyes watering or discharge** | ☐ | ☐ | **Urinary frequency** | ☐ | ☐ |
| **Loss of hearing** | ☐ | ☐ | **Urinary incontinence** | ☐ | ☐ |
| **Nasal passage blockage** | ☐ | ☐ | **Muscle weakness** | ☐ | ☐ |
| **Sore throat** | ☐ | ☐ | **Easy bruising** | ☐ | ☐ |
| **Chest pain or discomfort** | ☐ | ☐ | **Joint Pain, where_____** | ☐ | ☐ |
| **Palpitations** | ☐ | ☐ | **Dizziness** | ☐ | ☐ |
| **Feeling of the feet being cold** | ☐ | ☐ | **Fainting** | ☐ | ☐ |
| **Shortness of breath** | ☐ | ☐ | **Depression** | ☐ | ☐ |
| **Cough** | ☐ | ☐ | **Skin Lesion** | ☐ | ☐ |
| **Coughing up blood** | ☐ | ☐ | **Numbness or tingling in legs/feet** | ☐ | ☐ |
| **Nausea** | ☐ | ☐ | **Swelling in legs/feet** | ☐ | ☐ |
| **Vomiting** | ☐ | ☐ | **Other:** | ☐ | ☐ |

**Family History:** (please select all that apply)

| | Father | Mother | Brother | Sister |
|---|---|---|---|---|
| **Breast Cancer** | | | | |
| **Ovarian Cancer** | | | | |
| **Other Cancer** | | | | |
| **Heart Disease** | | | | |
| **Stroke** | | | | |
| **Hypertension** | | | | |
| **Diabetes** | | | | |
| **Atherosclerotic Vascular Disease** | | | | |
| **Aneurysm** | | | | |
| **Other (please specify)** | | | | |

*For nurse, only*: BP_____ HR _____ Temp _____ RR _____ Sat _____ Ht _____ Wt _____

**Patient Signature:** _____ **Date:** _____

SURGICAL SPECIALISTS OF SOUTHWEST FLORIDA, P.A. & SWFL VASCULAR CENTER

# New Patient Forms

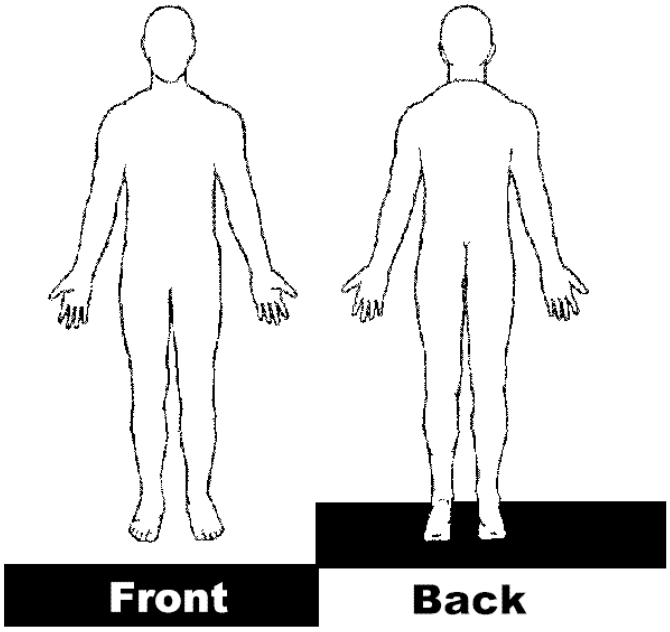
**Have you had any x-rays or tests to evaluate current problem?** ☐ No ☐ Yes, please explain_____

**Have you had a similar problem before?** ☐ Yes ☐ No If Yes, how long ago? _____

**Do you have pain related to your current problem**? ☐ Yes ☐ No

If **YES**, pleas CONTINUE with questionnaire. If **NO**, please STOP and CONTINUE ON THE OTHER SIDE

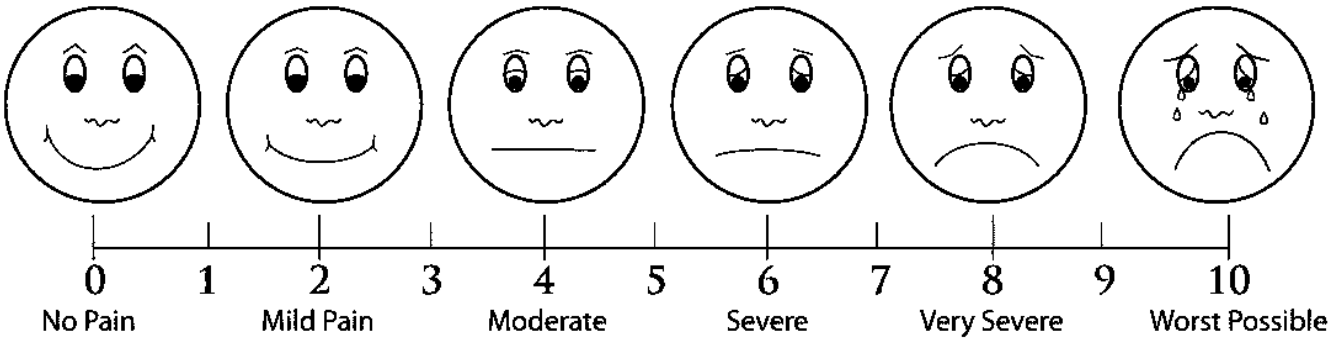
**Where is the pain?** (mark an "X" on the diagram)




**Describe your pain/symptoms:** (check if applicable)

- ☐ Stays all the time
- ☐ Comes and goes
- ☐ Pressure
- ☐ Throbbing
- ☐ Numbness
- ☐ Aching
- ☐ Dull
- ☐ Sharp
- ☐ Heavy
- ☐ Burning
- ☐ Tingling
- ☐ Gnawing
- ☐ Shooting
- ☐ Pricking

**Please, rate your pain/comfort level using the scale below:**




What is your goal for pain relief using above scale? _____

What activities/positions increase your pain? _____

What activities/positions decrease your pain? _____

What activities does pain interfere with or prevent you from doing? _____

**Patient Signature: _____ Date: _____**

SURGICAL SPECIALISTS OF SOUTHWEST FLORIDA, P.A. & SWFL VASCULAR CENTER

# New Patient Forms

**Allergies:** ☐ None **Latex Allergy:** ☐ Yes ☐ No

Medication Allergies Reaction

_____

_____

_____

_____

Food Allergies: ☐ No ☐ Yes _____

Dye/Tape Allergies: ☐ No ☐ Yes _____

Shellfish/Iodine Allergies: ☐ No ☐ Yes _____

**Current Medications:** ☐ Check here if attaching a home medication list

**Preferred Pharmacy:** Name_____ Phone Number: _____

Is this a mail-in pharmacy? ☐ Yes ☐ No

| Medication | Dosage | Times per day | Prescribing Doctor |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Patient Signature:** _____ **Date:** _____

SURGICAL SPECIALISTS OF SOUTHWEST FLORIDA, P.A. & SWFL VASCULAR CENTER

# New Patient Forms

**Social History:** Advanced Directives (Living will): ☐ Yes ☐ No

Occupation: _____ | ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Alcohol: ☐ No ☐ Yes Drinks per day/week: _____

Drug Use or Addiction: ☐ No ☐ Yes Drug(s): _____ Caffeine use: ☐ No ☐ Yes How often? _____

**Past Medical History:** ☐ No Medical History | Check all that apply

- ☐ Aortic Aneurysm
- ☐ Carotid Artery Stenosis
- ☐ Stroke
- ☐ Peripheral Arterial Disease
- ☐ Varicose Veins
- ☐ Hypertension
- ☐ Heart Disease
- ☐ Intermittent Claudication
- ☐ Irregular heart beat
- ☐ Murmur
- ☐ Heart Attack (MI)
- ☐ Venous insufficiency
- ☐ Colitis
- ☐ Constipation
- ☐ Diverticulosis/Diverticulitis
- ☐ Gallbladder disease
- ☐ Esophageal reflux
- ☐ Gastrointestinal Bleeding
- ☐ Hernia: _____
- ☐ Hemorrhoids
- ☐ Irritable Bowel Syndrome
- ☐ Intestinal obstruction
- ☐ Asthma
- ☐ COPD
- ☐ Chronic Kidney Disease
- ☐ Colon polyps
- ☐ Hematuria
- ☐ Kidney stones
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Anxiety
- ☐ Sleep Apnea
- ☐ Asthma
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Diabetes Mellitus
- ☐ Neuropathy
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Hepatitis
- ☐ HIV
- ☐ Tuberculosis
- ☐ Alzheimer's Disease
- ☐ Chronic Pain
- ☐ Dementia
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Seizure Disorder
- ☐ Anemia
- ☐ Coagulation Defects
- ☐ Sickle Cell Disease
- ☐ DVT: _____
- ☐ Pulmonary Embolism
- ☐ Cancer: _____
- ☐ Other: _____

**Past Surgical History:** ☐ No Surgical History | Please list surgeries and approximate date

- ☐ Aneurysm Repair
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Arthroscopy
- ☐ AV Graft/Fistula
- ☐ Brain Surgery
- ☐ Breast Biopsy
- ☐ Cataract Removal
- ☐ Cardiac Bypass
- ☐ Gallbladder Removal
- ☐ Heart Catherization
- ☐ Heart valve replacement
- ☐ Hemorrhoidectomy
- ☐ Hernia: _____
- ☐ Hysterectomy
- ☐ Kidney Removal
- ☐ Mastectomy [ ] L [ ] R
- ☐ Pacemaker
- ☐ Implanted Defibrillator
- ☐ Prostate Surgery
- ☐ Spine (back/neck)
- ☐ Splenectomy
- ☐ Thyroid Surgery
- ☐ Tonsils/Adenoids
- ☐ Total Hip [ ] L [ ] R
- ☐ Total Knee [ ] L [ ] R
- ☐ Tubal Ligation

Other: _____
Other: _____
Other: _____

**Patient Signature:** _____ **Date:** _____

## GENERAL PATIENT INFORMATION

Patient (FULL, LEGAL) Name: _____

Date of Birth: _____ Social Security Number (required): _____

Referring Physician: _____ Family Physician: _____

Patient Gender: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Preferred Language: _____ Have you ever been a patient in this practice before? ☐ Yes ☐ No

Ethnicity (select one): ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐ Black/African American ☐ American Indian ☐ Asian ☐ White ☐ Hawaiian/Pacific Island ☐ Other_____

Home Address: _____

Alternate Address (If applicable): _____

E-Mail:_____ Home: _____ Cell: _____

Emergency Contact: _____ Phone#: _____

Patient Employer Name: _____ Phone#: _____

**I DO NOT HAVE INSURANCE AND PLAN TO PAY FOR TODAY'S VISIT WITH:**

☐ Cash ☐ Check ☐ MasterCard ☐ Visa ☐ Discover ☐ American Express

**YOUR INSURANCE CARDS, PHOTO I.D., and CO-PAY IS REQUIRED AT TIME OF SERVICE.**

Primary Insurance: _____ Secondary Insurance: _____

*Are you the policyholder for your primary insurance:* ☐ Yes ☐ No – If no, complete the information below:

Policyholder's Name: _____ DOB: _____ SSN #: _____

*Are you the policyholder for your secondary insurance:* ☐ Yes ☐ No – If no, complete the information below:

Policyholder's Name: _____ DOB: _____ SSN #: _____

My signature below acknowledges that I understand that I am financially responsible for all charges provided to me, including the balance remaining after payment of possible insurance benefits. I assign the benefits payable for the physician's services to the physician furnishing the services.

**Patient Signature:** _____ **Date:** _____

# CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name: _____ SSN#: _____

☐ I give my permission to **Surgical Specialists of Southwest Florida, P.A.**, to disclose my protected health information to the following family or friends:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

**OR**

☐ I request that all my protected health information be disclosed only to "Me" and no one else other than my other healthcare providers.

**May we leave a message on your answering machine/voice message about your medical care? ☐ Yes ☐ No**

By signing this form, you are granting consent to Surgical Specialists of Southwest Florida to use and disclose your protected health information for purposes of treatment payment, and health care operations. I authorize the release of my medical records to any physicians to whom I am referred. I understand that I am financially responsible for all charges of services to me, including the balance remaining after payment of possible insurance benefits. I assign the benefits payable for physicians' services to the physician furnishing the services.

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by calling our office at (239) 936-8555. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent. A copy of this form is to be considered valid as an original.

***We utilize an automated system to remind you of your next appointment. By signing this you also give us permission to include you in this automated calling system. If you do not wish to be reminded of future appointments, please let the receptionist know this.***

**Patient Signature: _____ Date: _____**

# SURGICAL SPECIALISTS OF SW FL FINANCIAL POLICY

As a courtesy to you, we bill your primary insurance company for you. You are accepting responsibility for the charges that your insurance company does not pay.

**Managed Care:** All patients who have an insurance co-pay will be expected to pay **on** the day service is provided. Patients who are unable to pay at the time of service **will be assessed a $10.00 service charge or rescheduled**. This will not be billed to your insurance, but will be your personal responsibility.

**Medicare:** We participate in Medicare Part B. We will bill all services for you. You are responsible for your annual Medicare deductible and the 20% patient responsibility. You are also responsible for any services that Medicare considers non-covered or that Medicare denies as not medically necessary.

**Secondary Insurance after Medicare:** We will gladly bill any secondary or Medigap insurance that crosses electronically from Medicare to the secondary insurance.

**We DO NOT accept Medicaid as a primary insurance plan**. We will ONLY accept Medicaid as a secondary to Traditional Medicare.

**Uninsured:** If you are paying for services yourself (self-pay), an approximate amount for the anticipated services is **expected to be paid prior to the service**. Any additional charges as a result of your visit will also be collected.

If you have a balance due on your account, we will mail you a monthly statement. The statement will show separately any previous balance, any new charges to your account, and any payments or credits applied to your account during the month. Your responsibility will be clearly indicated by the arrow marked “Please Pay This Amount”. The balance is due and payable when the statement is issued and past due if payment is not received within thirty (30) days of the issue date on the statement. We reserve the right to add any fees incurred by us for additional billing and/or collection services. For your convenience, we accept most major credit cards, bank debit cards, and personal checks.

**Returned Check**: There is a minimum fee of $30.00 for any checks returned by your bank. You will also be responsible for any bank fees or currency exchange rate differentials if your check is not drawn on a bank in the US.

You understand that if your account is submitted to an attorney or collection agency, it may result in litigation in court, or your past due account being reported to a credit reporting agency, the fact that you have received treatment/services at our office may become a matter of public record. **Non-payment of overdue balances may jeopardize continued care with Surgical Specialists of Southwest Florida.**

Transferring of records may be requested in writing along with a Medical Records Release form. There is a charge for these records.

**Co-pays/Deductibles**: We cannot waive co-pays or deductibles, as this would be a breach of our contract with your insurance carrier. If there is a billable office visit, we are required to collect your co-pay.

**Non-payment**: If your account becomes 90 days past due, you will receive a pre-collection letter. If, however, your account remains unpaid and we forward your account to an outside collection agency, the account will be assessed a 33% collection fee over and above the remaining balance.

## ASSIGNMENT OF INSURANCE BENEFITS

## ACCEPTANCE OF FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all allowable charges not covered by my insurance, if they choose to arbitrarily deny these services as "non-covered". I agree to follow all office policies set by Surgical Specialists of SW Florida, PA. By signing below, I understand and agree that I am responsible for payment of services rendered to me by Surgical Specialists of SW Florida. I further agree that if my insurance company has not paid for services rendered, I will pay said fees and work with my insurance company for my own reimbursement.

I hereby acknowledge receipt of a copy of this policy and agree to the terms contained herein.

Patient/responsible party signature: _____

Printed name: _____

Witness: _____ Date: _____