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

New Patient Form

GENERAL PATIENT INFORMATION

Patient (FULL, LEGAL) Name: _____

Date of Birth: _____ Last Four Digits of SSN: _____

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#: _____

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:

Primary and/or Secondary Insurance Policyholder's Name: _____

I understand and consent that Physicians Assistants, Nurses, Medical Assistants, other healthcare providers in training or independent agents permitted to use this facility for patient care, may participate in my care under appropriate supervision.

My signature below acknowledges that I understand and agree to all the information contained in this consent. I also understand that I am financially responsible for any out-of- pocket costs, including co-pays, co-insurance and/or deductible 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:** _____

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New Patient Form

Name: _____ **DOB:** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Weight_____ **Height**_____

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

Social History: Occupation (previous occupation if retired): _____

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

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

SURGERIES: YES or NO (if yes, please complete table below)

TYPE OF SURGERY	SURGERY DATE

ILLNESSES: YES or NO (if yes, please complete table below)

Illness	Date	Hospital Stay

PAST MEDICAL HISTORY (please check all that apply)

DOB: _____

	Yes	No		Yes	No
Anemia	☐	☐	**Abdominal Pain**	☐	☐
Varicose Veins	☐	☐	**Low Blood Pressure**	☐	☐
Asthma	☐	☐	**Bloody stool**	☐	☐
Bleeding or Clotting Problems	☐	☐	**Kidney Problems**	☐	☐
DVT/Where?	☐	☐	**Urinary incontinence**	☐	☐
High Cholesterol	☐	☐	**Muscle weakness**	☐	☐
High Blood Pressure	☐	☐	**Easy bruising**	☐	☐
Chest pain or discomfort	☐	☐	**Joint Pain, where_____**	☐	☐
Palpitations	☐	☐	**Dizziness**	☐	☐
Feeling of the feet being cold	☐	☐	**Fainting**	☐	☐
Shortness of breath	☐	☐	**Heart Disease**	☐	☐
Cough	☐	☐	**Heart Attack**	☐	☐
Coughing up blood	☐	☐	**Numbness in hands/legs/feet**	☐	☐
HIV	☐	☐	**Tingling in hands/legs/feet**	☐	☐
Vomiting	☐	☐	**Swelling in legs/feet**	☐	☐

Family History: (please select all that apply)

	Father	Mother	Brother	Sister
Cancer/what type?				
Bleeding Problems				
Blood Clot				
Heart Disease				
Stroke				
High Blood Pressure				
Diabetes				
Vascular Disease				
Abdominal Aneurysm				
Stroke/TIA				

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

ALLERGIES AND MEDICATIONS DOB: _____

Food Allergies: ☐ No ☐ Yes _____

Dye Allergies: ☐ No ☐ Yes _____

Shellfish/Iodine Allergies: ☐ No ☐ Yes _____

DO YOU TAKE OVER THE COUNTER OR HERBAL MEDICATIONS ON A REGULAR BASIS? YES or NO

Medication	Dosage	Frequency of Use

DO YOU TAKE PRESCRIPTION MEDICATION? YES or NO

☐ Check here if attaching a home medication list

Medication	Dosage	Times per day	Prescribing Doctor

Preferred Pharmacy: Name_____ Phone Number: _____

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

CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name: _____ DOB: _____

☐ 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 SWFL, P.A.

PATIENT FINANCIAL POLICY & NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

As health care providers we are committed to providing our patients with the best medical care possible. As a business, we are committed to providing a streamlined fiscal process that allows our patients to clearly understand their financial responsibility. Our business office is committed to providing outstanding customer service for all financial questions, and our professional staff members are experts working with commercial insurance companies, Medicare, and Workers Compensation.

Commercial Health Insurance

- **Co-Payment**
  - **Insurance companies require that co-payments are collected prior to service**
- **Co-Insurance / Deductibles**
  - **New co-insurance or deductible amounts will be collected prior to any scheduled surgery.**
  - **These amounts can only be calculated after your appointment.**
- **Non-Participating Insurance**
  - **SSSWFL does not contract with every insurance company**
  - **Patients are responsible for asking if SSSWFL is a participating provider with their insurance company**
  - **SSSWFL will bill non-participating insurance. However, outstanding balances are the responsibility of the patient**
- **Secondary Insurance – as a courtesy SSSWFL will file to your secondary insurance carrier at the time**

Medicare

- **SSSWFL will submit claims to Medicare, however you may need to sign an ABN form for all diagnostic services.**
- **SSSWFL will submit to Medicare as your secondary insurance carrier one time**

Workers Compensation

- **Patients claim adjusters shall supply WC contact information prior to services being rendered.**

Motor Vehicle / Third Party Liability

- **Patients are financially responsible for medical services related to motor vehicle accidents**
- **Patients shall supply auto insurance, third party, and / or attorney information as requested by SSSWFL**

Self-Pay

- **Self-pay accounts exist if patients have no insurance coverage**
- **Full payment is due at the time of service of all self-pay patients**

Statements / Payments

- **Statements**
  - **Statements are sent to patients on a monthly basis and will show outstanding balances.**
  - **After insurance pays, patients are responsible for all outstanding co insurance and/or deductibles.**
- **Payment Methods**
  - **We accept all major credit cards, checks, money orders, and cash**

- **Returned Check Fee a fee of $35.00 will be charged for all returned checks**
- **A fee of $50 will be charged for all missed appointments or no-show. Initial here_____**

I _____, hereby assign to Surgical Specialists of SWFL, payments of medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine my benefits. This authorization shall remain valid until written notice is given by me revoking said authorization.

Sign: _____ Date_____

Patient Health Questionnaire (PHQ-9)

Date of visit: _____

Patient Name: _____ DOB: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not At all**	**Several Days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
2. Feeling down, depressed, or helpless	☐ 0	☐ 1	☐ 2	☐ 3
3. Trouble falling asleep, staying asleep, or sleeping too much	☐ 0	☐ 1	☐ 2	☐ 3
4. Feeling tired or having little energy	☐ 0	☐ 1	☐ 2	☐ 3
5. Poor appetite or overeating	☐ 0	☐ 1	☐ 2	☐ 3
6. Feeling bad about yourself – or that you're a failure or have let yourself or your family down	☐ 0	☐ 1	☐ 2	☐ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐ 0	☐ 1	☐ 2	☐ 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐ 0	☐ 1	☐ 2	☐ 3
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐ 0	☐ 1	☐ 2	☐ 3
OFFICE STAFF ONLY	**Column Totals**	_____ + _____ + _____ + _____		
	Add totals together	_____		

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Date of Visit: _____

Patient Name: _____ DOB: _____

FALL RISK SELF ASSESSMENT

This form must be completed once a year. Circle “yes” or “no” for each statement.

I have fallen in the past year.	YES (2)	NO
I use or have been advised to use a cane or walker.	YES (2)	NO
I sometimes lose my balance when walking.	YES (1)	NO
I worry about falling.	YES (1)	NO
I use my arms to push myself up from a chair.	YES (1)	NO
I sometimes have trouble stepping up onto a curb.	YES (1)	NO
My body sways when standing stationary.	YES (1)	NO
I take short narrow steps.	YES (1)	NO
I stumble often or look at the ground when I walk.	YES (1)	NO
I frequently have to rush to the toilet.	YES (1)	NO
I have lost some feeling in one or both of my feet.	YES (1)	NO
My medication makes me light-headed or sleepy.	YES (1)	NO

YOUR FALL RISK ➔

DISCUSS WITH US AND CONTACT YOUR PCP!

0	1	2	3	4	5	6+
LOW	**MODERATE**	**AT RISK**	**HIGH**	**URGENT**		**SEVERE**