Suede Surgical Care

PATIENT REGISTRATION

LAST NAME _____ **FIRST NAME**_____ **MI** ____ **D.O.B.** _____

ADDRESS _____ **APT** _____

CITY _____ **STATE** _____ **ZIP** _____

HOME PHONE (___) _____ **CELL** (___) _____ **WORK** (___) _____

SOCIAL SECURITY # ___–___–____ **WORKING**– FT / PT / RETIRED / NOT EMPLOYED / STUDENT

EMPLOYER _____ **OCCUPATION** _____

MARITAL STATUS – M / S / D / W **GENDER** – MALE / FEMALE **ETHNICITY** – HISPANIC / NON HISPANIC

RACE – WHITE OR CAUCASIAN / BLACK OR AFRICAN AMERICAN / ASIAN / OTHER _____

WAS THE CURRENT REASON FOR YOUR VISIT A RESULT OF A MOTOR VEHICLE ACCIDENT OR INJURY AT WORK? YES NO

CIRCLE ONE: MOTOR VEHICLE ACCIDENT WORKER'S COMP DATE OF ACCIDENT/ iNJURY:_____

PHYSICIAN INFORMATION

PRIMARY CARE PHYSICIAN _____ **REFERRING PHYSICIAN** _____

SPOUSE/PARTNER/PARENT OR GUARDIAN INFORMATION

LAST NAME _____ **FIRST NAME**_____ **MI** ____ **D.O.B.** _____

ADDRESS _____ **APT** _____

CITY _____ **STATE** _____ **ZIP** _____

HOME PHONE (___) _____ **CELL** (___) _____ **WORK** (___) _____

SOCIAL SECURITY # ___–___–____ **WORKING**– FT / PT / RETIRED / NOT EMPLOYED / STUDENT

EMPLOYER _____ **OCCUPATION** _____

EMERGENCY CONTACT

NAME _____ **PHONE** _____

RELATIONSHIP _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ SUBSCRIBER _____ SUBSCRIBER DOB _____

SECONDARY INSURANCE _____ SUBSCRIBER _____ SUBSCRIBER DOB _____

I hereby assign all medical/surgical benefits to which I am entitled to the above providers for Suede Surgical Care, for services performed by them. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not said charges are reimbursed by insurance. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. I further permit a copy of this authorization to be used in the place of the original. I also understand that if this account must be turned over to an attorney to collections, I will be responsible for all attorney and court fees.

SIGNATURE OF PATIENT OR GUARDIAN _____ DATE _____

SEE BACK

SUEDE SURGICAL CARE, LLC

HIPPA PRIVACY RESTRICTION QUESTIONNAIRE

PATIENT NAME _____ DOB _____

MAY WE CALL YOUR HOME: YES / NO MAY WE CALL YOUR WORK: YES / NO

IF NO, PROVIDE AN ALTERNATE NUMBER: ____(_____)_____

MAY WE SEND YOU A FAX: YES / NO FAX #: __(_____)_____

MAY WE CONTACT YOU VIA EMAIL: YES / NO EMAIL ADDRESS: _____

MAY WE LEAVE MESSAGES (INCLUDING LAB RESULTS) ON YOUR ANSWERING MACHINE/VOICEMAIL YES / NO

MAY WE SPEAK TO ANOTHER FAMILY MEMBER REGARDING YOUR TREATMENT YES / NO

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

FOR MINORS: CALL MOTHER ONLY / CALL FATHER ONLY / CALL EITHER PARENT

NAME OF CHILDREN THAT APPLY TO THESE RESTRICTIONS:

_____ _____

_____ _____

CONSENT AND ACKNOWLEDGEMENT

I consent to the use or disclosure of my protected health information by Suede Surgical Care, LLC to any person or organization for the purpose of carrying out treatment, obtaining payment or conducting certain health care operations. Protected health information used or disclosed by Suede Surgical Care, LLC may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information, as long as such information is used to disclose in accordance with the Connecticut and Federal law, which may require you to provide specific authorization. I understand that information regarding how Suede Surgical Care, LLC will use and disclose my information can be found of the Notice of Privacy Practices. I understand that this consent is effective for as long as Suede Surgical Care, LLC maintains my protected health information. By signing below, I understand and acknowledge the following:

- I have read and understand this consent, and
- I have received a copy of the Notice of Privacy Practices currently in effect.

_____ _____ _____

NAME SIGNATURE DATE

If signed by a person of legal representation, please describe your legal authority to act on behalf of the individual.

Describe _____

Signature _____ Date _____

HEALTH HISTORY

NAME: _____ D.O.B.:_____

OCCUPATION: _____

HOBBIES: _____

LAST PHYSICAL EXAM: _____

HABITS:

SMOKING: YES / NO / FORMER

-IF YES, # OF PACKS/DAY: _____

-IF FORMER, WHEN DID YOU QUIT? _____

ALCOHOL: YES / NO

STREET DRUGS: YES / NO IF YES, WHAT TYPE: _____

PLEASE LIST ALL YOUR ALLERGIES:

_____

_____

_____

_____

PLEASE LIST ALL OF YOUR MEDICATIONS AND VITAMINS, INCLUDING DOSAGES:

_____

_____

_____

_____

PLEASE LIST ILLNESSES, OPERATIONS, AND OTHER HOSPITALIZATIONS:

_____

_____

_____

SEE BACK

HEALTH HISTORY

PAST MEDICAL HISTORY:

HEART DISEASE	YES / NO	DIABETES	YES / NO
PNEUMONIA	YES / NO	STROKE	YES / NO
HERNIA	YES / NO	THYROID	YES / NO
AIDS / HIV	YES / NO	ULCERS	YES / NO
ASTHMA	YES / NO	ARTHRITIS	YES / NO
HEPATITIS	YES / NO	BACK ISSUES	YES / NO
EPILEPSY	YES / NO	BRONCHITIS	YES / NO
TUBERCULOSIS	YES / NO	BLADDER INFECTION	YES / NO
BLOOD TRANSFUSION	YES / NO	HIVES / ECZEMA	YES / NO
BLEEDING TENDENCY	YES / NO	HIGH / LOW BLOOD PRESSURE	YES / NO
KIDNEY DISEASE	YES / NO		

CANCER YES / NO - TYPE OF CANCER _____

_____

FAMILY MEDICAL HISTORY:

DIABETES	MOTHER / FATHER
THYROID DISEASE	MOTHER / FATHER
STROKE	MOTHER / FATHER
HEART DISEASE	MOTHER / FATHER
HIGH BLOOD PRESSURE	MOTHER / FATHER

CANCER MOTHER / FATHER – TYPE OF CANCER _____

_____

DO YOU HAVE NOW OR HAVE HAD WITHIN THE LAST YEAR:

WEAKNESS OR PARALYSIS	YES / NO	RECENT WEIGHT CHANGE	YES / NO
CHANGE IN APPETITE	YES / NO	SENSITIVITY TO COLD OR HOT	YES / NO
SKIN CHANGE	YES / NO	VISION CHANGE	YES / NO
SORE THROAT	YES / NO	BLOODY SPUTUM	YES / NO
PALPITATIONS	YES / NO	VOMITING	YES / NO
DEPRESSION	YES / NO	HEADACHES	YES / NO
RECTAL BLEEDING	YES / NO	HEMORRHOIDS	YES / NO
PERSISTENT FEVER	YES / NO	LUMP IN BREAST	YES / NO
CHEST PAIN	YES / NO	LEG CRAMPS	YES / NO
NAUSEA	YES / NO	JAUNDICE	YES / NO
DIZZINESS	YES / NO	NIGHT SWEATS	YES / NO
NOSE BLEED	YES / NO	HEART BURN	YES / NO
EASY BRUISING	YES / NO	ABDOMINAL CRAMPING	YES / NO
BLACK TARRY STOOL	YES / NO	CHRONIC DIARRHEA	YES / NO
SHORTNESS OF BREATH	YES / NO	SWELLING OF HANDS / FEET	YES / NO

_____

WOMEN ONLY:

AGE PERIOD BEGAN _____ LAST PELVIC EXAM _____

HOW MANY DAYS DOES YOUR PERIOD LAST _____

DO YOU USE BIRTH CONTROL: YES / NO

WHAT TYPE: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or my child's) health. It is my responsibility to inform the doctor's office of any change in my (or my child's) medical status. I also authorize the health care staff to perform the necessary health care I (or my child) need.

_____ _____

SIGNATURE OF PATIENT OR PARENT IF MINOR **DATE**