Mid La Surgical Specialists

Patient Information Sheet

(PLEASE PRINT CLEARLY)

PATIENT INFORMATION DATE:

First Name:_____ M.I. _____ Last:_____

Address: _____City/St/Zip:_____

Home Phone: (___)_____ Work #: (___)_____ Cell #: (___)_____

Date of Birth:_____ Social Security #:_____ E-mail:_____

Sex: ☐ Male ☐ Female Marital Status: _____ Drivers License #: _____

Preferred Pharmacy: _____ Location: _____

Employer: _____ Occupation: _____

Employer's Address: _____City/St/Zip:_____

If Patient is a child/minor please provide the following:

Mother's Name: _____ Mother's SS #:_____

Date of Birth: _____ Employer:_____ Work Tel: (____)_____

Father's Name: _____ Father's SS #:_____

Date of Birth: _____ Employer:_____ Work Tel: (____)_____

SPOUSE INFORMATION

First Name:_____ M.I. _____ Last:_____

Social Security #:_____ Date of Birth: _____

Employer: _____ Occupation: _____

Employer's Address: _____City/St/Zip:_____

EMERGENCY CONTACT

Name: _____ Relationship to you: _____

Tel (H): (____)_____ Tel (W): (____)_____ Cell: (____)_____

Address: _____

(YOU MUST COMPLETE & SIGN THE BACK OF THIS FORM!)

MEDICATION HISTORY CONSENT

An accurate medication history is very important in helping our physicians provide you with quality health care and assists in avoiding potentially dangerous drug interactions.

I hereby give my consent to Mid Louisiana Surgical Specialists to electronically obtain my medication history.

_____

Patient Signature / Legal Guardian

*Electronic information from your pharmacy and/or health insurance provider might not be complete. It's very important that you inform your physician of all medications that you routinely take, including over-the-counter medicine, vitamin supplements and herbal remedies.

REQUIRED INFORMATION

Medicare, in their efforts to assure that all patients have equal access to quality patient care, requires that we obtain the following information on all of our patients. We appreciate your assistance!

Do you consider yourself Hispanic/Latino? Yes No

Which category best describes your race? American Indian Asian Black/African American White Other:_____

PHOTO CONSENT – PROTECTED HEALTH INFORMATION

I understand that, in an effort to prevent medical identity theft, MLSS policy requires that my photo be placed in my medical record. I hereby consent to a photograph being made of me or my child/dependant. I understand that it is solely for the purpose of protecting my identity and protected health information_____

SIGNATURE

AUTHORIZATION FOR RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

I authorize the physicians and staff on this case to release medical information to the pertinent insurance company(s) or third party carriers and request that payment be made directly to the billing entity. I also request that payment of benefits from my secondary insurance carrier be paid directly to the billing entity until otherwise notified.

OFFICE POLICY

1. I understand that I am financially responsible for any balance not covered by my insurance carrier.
2. I understand that co-payments are due at the time of my visit.
3. I understand that I am required to pay my portion of any surgery/procedure charges prior to the procedure date.
4. I understand that I am responsible for informing the receptionist of any changes in address or insurance coverage.
5. I understand that my insurance card must be shown at each visit.
6. I understand that I am responsible for providing a referral from my primary care physician (PCP), should my insurance carrier require one, and that if one is not received my appointment will be canceled.
7. I understand that, in the event my account is turned over for collection, I will be responsible for payment of reasonable legal fees to collect same.
8. A copy of Mid Louisiana Surgical Specialists' financial policy has been made available to me.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Guardian/Responsible Party Date

Mid La Surgical Specialists

A Professional Medical Corporation

Wayne L. Watkins, M.D., F.A.C.S. J. Michael Conerly, M.D., F.A.C.S.
Darryl J. Aguilar, M.D., F.A.C.S. James N. Parrish, M.D., F.A.C.S.
Samuel E. Bledsoe, M.D.

This notice describes how information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

Notice of Privacy Practices

Effective Date: April 09, 2003

1. Mid La Surgical Specialists may use and disclose protected health information for treatment, payment and healthcare operations. Examples of these include, but are not limited to, requested preschool, life insurance or sports physicals, referral to nursing homes, foster care homes, home health agencies and/or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers; collection agencies. Healthcare operations include, but is not limited to, internal quality control and assurance including auditing of records.

2. Mid La Surgical Specialists is permitted or required to use or disclose protected health information without the individuals written consent or authorization in certain circumstances. Two examples of such are for public health requirements or court orders.

3. Mid La Surgical Specialists will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.

4. Mid La Surgical Specialists may at times contact the patient to provide appointment reminders or information regarding treatment alternatives or other health-related benefits and services that may be of interest to the individual patient.

5. Mid La Surgical Specialists will abide by the terms of this notice currently in effect at the time of disclosure.

6. Mid La Surgical Specialists reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains.

7. Mid La Surgical Specialists will provide each patient with a copy of any revisions of it's Notice of Information Practice at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our office.

8. Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Officer at the following address and/or phone number: Annette Holden, Office Manager, 3311 Prescott Rd., Suite 201, Alexandria, LA 71301. Phone: 318-442-6767.

9. It is Mid La Surgical Specialists' policy that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

10. Patient's Name (please print) _____

11. Date:_____

12. Signature of Patient or Legal Guardian _____

3311 Prescott Rd., Suite 201 • Alexandria, LA 71301
Phone (318) 442-6767 • Fax (318) 449-3986

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Dr. Samuel E. Bledsoe, M.D.

Authorization for Release of Protected Health Information

Patient Identification

Printed Name:_____ **Date of Birth:** _____

Address: _____

_____

Social Security #:_____ **Telephone:** _____

Authority to Release Protected Health Information

IMPORTANT!! List all persons (doctors, family, friends, etc.) that you authorize Mid La Surgical Specialists to release your medical information to. **Anyone **not listed** will be **unable** to receive any of your medical information, written or verbal, from this clinic.

I hereby authorize Mid La Surgical Specialists to release the information identified in this authorization form from the medical records of Mid La Surgical Specialists and provide such information to:

 Referring physician(s)/Medical Facilities
List Physicians/Medical Facilities_____

_____

 Family/Relative/Friend
Name/Relationship to you: _____
Name/Relationship to you: _____
Name/Relationship to you: _____
Name/Relationship to you: _____

Information To Be Released

Please check type of information to be released:

□ Complete health record	□ Diagnosis & treatment codes	□ Discharge summary
□ History and physical exam	□ Consultation reports	□ Progress notes
□ Laboratory test results	□ X-ray reports	□ X-ray films / images
□ Photographs, videotapes	□ Complete billing record	□ Itemized bill

□ Other, (specify) _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or other sensitive information, I agree to its release.
Check One: ☐ **Yes** ☐ **No**

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release. ***Check One:*** ☐ **Yes** ☐ **No**

Right to Amend/Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, the authorization may be amended and/or revoked at any time by submitting a written notice to Mid La Surgical Specialists at, 3311 Prescott Road, Suite 201, Alexandria, LA 71301. Unless revoked, this authorization will expire on the following date, or after the following time period or event: End of Treatment Period.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. However, if health care services are being provided to me for the purpose of providing information to a third-party (e.g. fitness-for-work test), I understand that services may be denied if I do not authorize the release of information related to such health care services to the third-party. I can inspect or copy the protected health information to be used or disclosed. **I hereby release and discharge Mid La Surgical Specialists of any liability and the undersigned will hold Mid La Surgical Specialists harmless for complying with this Authorization.**

Signature: _____ Date: _____

Description of relationship if not patient:

_____

MID LOUISIANA SURGICAL SPECIALISTS
History and Physical

Patient Name: _____ **DOB:** _____ **Date:** _____

Referring Doctor: _____ **Family Doctor:** _____

Reason for visit: _____

PAST MEDICAL HISTORY - Check all that apply to YOU!

□ Number of Pregnancies _____
□ Number of Births _____
□ Asthma
□ Atrial Fibrillation
□ Anxiety
□ Autoimmune Disorder
□ CVA / Stroke
□ COPD-Emphysema
□ Coronary Heart Disease
□ Crohn's Disease
□ CRF-Renal Failure
□ Colon Cancer
□ Cataract Extraction
□ Anesthesia Complications
□ Blood Transfusion
□ Depression
□ Diabetes – insulin dep
□ Diabetes-non-insulin dep
□ GI Bleed
□ G E R D - reflux
□ Heart Disease
□ Hyperlipidemia
□ Hypertension
□ Hypothyroidism-Underactive
□ Hyperthyroidism-Overactive
□ Hepatitis A
□ Hepatitis B
□ Hepatitis C
□ Infertility
□ Cirrhosis
□ DVT-blood clots
□ Kidney Disease
□ Kidney Stone
□ Liver Disease
□ M I-Heart Attack
□ Neurologic Disorder
□ Osteoathritis
□ Osteoporosis
□ PVD-arterial disease
□ PUD – Gastric ulcers
□ Rheumatoid Arthritis
□ Skin Cancer
□ Seizure Disorder
□ Thyroid Disorder
□ Tuberculosis
□ Valvular Heart Disease
□ U T I – bladder infections
□ Brain Tumor
□ Varicose Veins/Phlebitis
□ Breast Disease
□ Cervical Cancer
□ Colon Polyps
□ Fibromyalgia
□ Breast Cancer

PAST SURGICAL HISTORY - Check all that apply to YOU!

□ None
□ Abdominal-exploratory
□ Amputation
□ Dialysis Access
□ C-Section
□ Aortic Valve Replacement
□ Appendectomy
□ Aortic Surgery
□ Back Surgery
□ Breast Biopsy
□ CABG-Heart Bypass
□ Carotid Endarterectomy
□ Carpel Tunnel
□ Cataract Surgery
□ Gallbladder
□ Colon Resection
□ Brain Surgery
□ Weight loss surgery
□ Hemorrhoidectomy
□ Hernia Repair
□ Hiatal Hernia Repair
□ Hip Replacement
□ Interventional Pain Procedure
□ Knee Scope
□ Knee Replacement
□ Mitral Valve Replace
□ Kidney Surgery
□ Pacemaker
□ Parathyroidectomy
□ Lung Surgery
□ Port Placement
□ Port Removal
□ Prostate Surgery
□ Heart stent
□ Rotator Cuff Repair
□ Splenectomy
□ Tubal Ligation
□ Hysterectomy w/o ovaries
□ Hysterectomy w/ovaries
□ Thyroidectomy
□ Tonsillectomy
□ Bladder Sling
□ Mastectomy/Lumpectomy
□ Anesthesia Problems
□ Surgical Complications

PAST FAMILY HISTORY - Check all that apply to IMMEDIATE FAMILY MEMBERS ONLY!

□ FH Anemia
□ FH Anesthetic Complication
□ FH Blood Clots
□ FH Breast Cancer
□ FH Colon Cancer
□ FH Diabetes
□ FH Heart Disease
□ FH Hypertension
□ FH Psychiatric Care
□ FH Stroke
□ FH Bowel Disease
□ FH Kidney Disease
□ FH Respiratory Disease
□ FH Liver Disease
□ FH Melanoma
□ FH Ovarian Cancer
□ FH Thyroid Disease
□ FH Weight Disorder

SOCIAL HISTORY – Circle/Complete all that apply to YOU!

MARITAL STATUS: Single Married Divorced Widow **LIVING ARRANGEMENTS:**

_____

(private residence, nursing home, etc)

ANY RELIGIOUS BELIEFS THAT WOULD AFFECT YOUR CARE?

_____

TYPE OF WORK:_____ **LEVEL OF EDUCATION:** _____

TOBACCO USE: _____ Never smoked _____ Current Smoker How long? _____ yrs # packs per day _____

_____Former Smoker How long since you quit? _____ months/years Are you exposed to second-hand smoke? Yes No

DRUG USE: Yes No **HIV RISK:** Yes No **ALCOHOL USE:** Yes No

Average _____ drinks per day

REGULAR EXERCISE: Yes No If yes, # of times per week: _____

Date of last Colonoscopy: _____ **Date of Last Mammogram:** _____

Review of Systems

Check all that apply to YOU!

GENERAL
- □ Fever
- □ Anorexia
- □ Weight loss

EYES
- □ Double vision
- □ Recent change in vision
- □ Eye pain
- □ Do you wear contacts/glasses? Yes No

GASTROINTESTINAL
- □ Abdominal Pain
- □ Nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Change in bowel habits
- □ Melena
- □ Blood in stool
- □ Jaundice
- □ Gas/bloating
- □ Indigestion/heart burn
- □ Dysphagia-difficulty swallowing

BREAST
- □ Left breast lump
- □ Right breast lump
- □ Nipple discharge
- □ Bloody nipple discharge
- □ Breast pain
- □ Abnormal mammogram
- □ Breast Enlargement
- □ Nipple/breast rash

CARDIOVASCULAR
- □ Chest Pain
- □ Palpitations-skipped beats
- □ Syncope-dizziness/fainting
- □ Peripheral edema-ankle swelling
- □ Shortness of breath

RESPIRATORY
- □ Cough
- □ Shortness of breath
- □ Coughing up blood
- □ Wheezing
- □ Pleuritic chest pain

VASCULAR
- □ Varicose veins
- □ Leg swelling
- □ Leg redness
- □ Leg coolness
- □ Pain in legs when walking
- □ Resting leg pain
- □ Pain in legs at night
- □ Blue toe(s)

GENITOURINARY (Female)
- □ Vaginal discharge
- □ Incontinence-urine leakage
- □ Dysuria-painful urination
- □ Blood in urine
- □ Frequent urination
- □ Abnormal Vaginal bleeding
- □ Pelvic Pain
- □ Is there a chance you are pregnant? Yes No

GENITOURINARY (Male)
- □ Painful urination
- □ Blood in urine
- □ Discharge
- □ Frequent urination
- □ Frequent night urination
- □ Difficulty urinating
- □ Incontinence-urine leakage
- □ Erectile dysfunction

WOUND
- □ Wound redness
- □ Wound drainage
- □ Wound pain
- □ Opening of wound
- □ Bleeding from wound
- □ Non-healing wound

DERMATOLOGY
- □ Suspicious lesions
- □ New skin lesions
- □ Changing mole(s)
- □ Rash
- □ Itching
- □ History of skin cancer
- □ SQ nodules (lumps)

NEUROLOGICAL
- □ Paralysis
- □ Numbness of an extremity
- □ Seizures
- □ Frequent headaches

PSYCHIATRIC
- □ Depression
- □ Anxiety
- □ Memory loss
- □ Suicidal thoughts
- □ Hallucinations
- □ Paranoia
- □ Phobia
- □ Confusion

ENDOCRINE
- □ Cold intolerance
- □ Heat intolerance
- □ Excessive thirst
- □ Excessive eating
- □ Unusual weight change

HEME
- □ Abnormal bruising
- □ Bleeding
- □ Enlarged lymph nodes
- □ Sickle cell anemia
- □ Recent fever infections

MUSCULOSKELETAL
- □ Back pain
- □ Sciatica-nerve issues
- □ Arthritis
- □ Bone/joint pain

OTHER
- □ Stoma redness
- □ Pain around stoma
- □ Discharge from stoma
- □ Pain from venous catheter
- □ Redness at vascular access site
- □ Purulent drainage from vascular access site.