Last Name,	First Name	MI	Last 4 of SSN

PATIENT INFORMATION

Madison Oak Drive ●Suite 220 ● San Antonio, TX 78258 Phone: (210) 494-7979

Please Print

PATIENT NAME: LAST, FIRST MI	SUFFIX	SEX M OR F	SOCIAL SECURITY NUMBER - -	DATE OF BIRTH / /
PHYSICAL ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE ( )
OCCUPATION	EMPLOYER	MARITAL STATUS ____S ____M ___W ____D		CELL PHONE ( )
E-MAIL ADDRESS	EMPLOYMENT STATUS F/T P/T ____EMPLOYED ____ UNEMPLOYED ____ SELF EMPLOYED ____ STUDENT			WORK PHONE ( )
SPOUSES NAME: LAST, FIRST MI	SUFFIX	CONTACT NUMBER ( )	OCCUPATION	
PERSON TO CONTACT IN CASE OF EMERGENCY (NOT RESIDING WITH YOU)				TELEPHONE ( )
REFFERRED BY: FIRST AND LAST NAME		PRIMARY PHYSICIAN: FIRST AND LAST NAME		

PRIMARY INSURANCE BILLING INFORMATION

(PROVIDE YOUR INSURANCE CARD TO THE FRONT DESK AT CHECK-IN) CHECK-IN)

INSURANCE COMPANY NAME		
MAILING ADDRESS		
POLICY HOLDER NAME: LAST, FIRST MI	STATE / ZIP CODE	
ID NUMBER	POLICY HOLDER SSN # - -	
GROUP NAME AND NUMBER	POLICY HOLDER DATE OF BIRTH / /	

SECONDARY BILLING INFORMATION

(PROVIDE YOUR INSURANCE CARD TO THE FRONT DESK AT

INSURANCE COMPANY NAME	
MAILING ADDRESS	
POLICY HOLDER NAME: LAST, FIRST MI	STATE / ZIP CODE
ID NUMBER	POLICY HOLDER SSN # - -
GROUP NAME AND NUMBER	POLICY HOLDER DATE OF BIRTH / /

PAYMENT POLICY

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office. In the event my account is turned over to an attorney for collections, I will pay any fee/costs incurred during the collection process.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Stone Oak General Surgery to furnish information to insurance carriers (including Medicare/Medigap) concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself of my dependants. I understand that I am responsible for any amount not covered by insurances.

I understand that Stone Oak General Surgery reserve the right to charge a $25.00 fee for missed appointments without at least 24-hour prior cancellation notice and to charge a $100.00 fee for any missed surgery/procedure without at least 48 hour cancellation notice. I certify that the information I provided above is correct.

_____ _____

Date Signature of Patient or Responsible Party

I acknowledge that I have been offered a copy of the Patient Privacy Notice of Stone Oak General Surgery. Copy taken____ Declined____

_____ _____

Date Signature of Patient / Legal Guardian

Last Name,	First Name	MI	Last 4 of SSN

Adult Health History Form

Madison Oak Drive ●Suite 220 ● San Antonio, TX 78258 Phone: (210) 494-7979

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please provide your best guess. **Thank You.**

How would you rate your general health today? □ Excellent □ Good □ Fair □ Poor

Main reason for today's visit:_____

MEDICAL HISTORY: SURGICAL HISTORY:

Major illnesses (i.e high blood pressure, high cholesterol, depression, etc)	Year of Diagnosis	Surgeries	Year of Surgery
1.		1.	
2.		2.	
3.		3.	
4.		4.	
5.		5.	
6.		6.	

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication/Vitamin/Supplement	Dose/Strength (e.g., mg/pill)	How many times per day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

ALLERGIES: Do you have allergies or reactions to Foods/ Latex/ Medication:

Item	Reaction
1.	
2.	
3.	
4.	

StoneOak GENERAL SURGERY

Last Name,	First Name	MI	Last 4 of SSN

REVIEW OF SYMPTOMS: Please check any **current** symptoms you have.

Constitutional
____ Unexplained weight loss/gain
____ Recent fevers/sweats
____ Unexplained fatigue/weakness
____ Recent chills/cold sweats

Cardiology
____ Chest pains/discomfort
____ Palpitations
____ Decreased exercise tolerance

Dermatology
____ Rash
____ New or change in mole

Endocrinology
____ Cold/heat intolerance
____ Increase thirst/appetite

ENT
____ Change in hearing
____ Congestion
____ Sinus pain
____ Sore throat

Hematology/Lymph
____ Unexplained lumps
____ Easy bruising/bleeding

Genitourinary
____ Painful/bloody urination
____ Leaking urine
____ Nighttime urination
____ Discharge: penis or vagina
____ Concern with sexual functions

Gastroenterology
____ Heartburn/reflux
____ Bloody stools
____ Change in bowel movement
____ Nausea/vomiting/diarrhea
____ Pain in abdomen

Musculoskeletal
____ Muscle/joint pain
____ Recent back pain
____ Weakness
____ Swollen joints

Neurology
____ Memory loss
____ Headaches
____ Fainting
____ Numbness/tingling
____ Loss of balance

Ophthalmology
____ Change in vision
____ Eye pain

Psychology
____ Anxiety/stress
____ Sleep problems

Respiratory
____ Cough/wheeze
____ Coughing blood
____ Short of breath with exertion
____ Pain with breathing

Women
____ No periods
____ Heavy periods
____ Painful periods
____ Irregular periods
____ Unusual vaginal bleeding

Pregnancy
____ Currently Pregnant _____wks
____ Pregnancies #_____
____ Deliveries #_____
____ Miscarriages #_____
____ Abortions #_____

Date of last period:

_____

Menopause at age:

_____

HEALTH MAINTENANCE: Date and result of most recent record.

Cholesterol _____ Abnormal? □ Yes □ No
Bone Density Scan _____ Abnormal? □ Yes □ No
Women: Mammogram _____Abnormal? □ Yes □ No
Colonoscopy _____Abnormal? □ Yes □ No
Men: PSA (prostate) _____ Abnormal? □ Yes □ No
Pap Smear _____ Abnormal? □ Yes □ No

FAMILY HISTORY: Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following:

Alcoholism _____
Cancer, specify type _____
Heart disease _____
Depression/suicide _____
Blood Disorders _____
Genetic disorders _____
Diabetes _____
Kidney disease _____
Anesthesia Complications _____
High cholesterol _____
High blood pressure _____
Stroke _____
COPD _____
Asthma _____
Anxiety _____
Other: _____

SOCIAL HISTORY:

Tobacco Use Cigarettes □ Never □ Quit Date _____
□ Current Smoker: packs/day _____ # of yrs _____
Other Tobacco: □ Pipe □ Cigar □ Snuff □ Chew
Are you interested in quitting? □ Yes □ No

Alcohol Use
Do you drink alcohol? □ Yes □ No # drinks/week _____
Is your alcohol use a concern for you or others? □ Yes □ No

Drug Use
Do you use any recreational drugs? □ Yes □ No
Have you ever used needles to inject drugs? □ Yes □ No

Caffeine Intake: □ None □ Coffee/tea/soda _____cups/day

Weight: Are you satisfied with your weight? □ Yes □ No
How do you rate your diet? □ Good □ Fair □ Poor
Diet: Do you eat or drink <u>four</u> servings of dairy or soy daily or take calcium supplements? □ Yes □ No

Exercise: Do you exercise regularly? □ Yes □ No
What kind of exercise?_____
How long (minutes)_____ How often?_____
If you do not exercise, why?_____
_____
_____