Patient Name: _____ Date of Birth: _____

PREFERRED PHARMACY INFORMATION

Pharmacy Name: _____ Phone #: _____ Fax #: _____
Location/Cross Streets: _____

ALLERGIES

No known medication/drug allergy: [ ]
Please list any medication/drug allergies: _____

MEDICAL HISTORY

	SELF	MOM	DAD	BROTHER	SISTER		SELF	MOM	DAD	BROTHER	SISTER
ANEMIA						HEART DISEASE					
ARTHRITIS						HEPATITIS					
ASTHMA						HIV/AIDS					
BLADDER PROBLEMS						HYPERTENSION					
BLOOD DISEASE						KIDNEY DISEASE					
CANCER						LUPUS					
COLITIS						SLEEP DISORDER					
COPD						STROKE					
DIABETES						TB					
EMPHYSEMA						THYROID DISEASE					
EPILEPSY						VISION IMPAIRMENT					
HEARING IMPAIRED						OTHER:					

SURGICAL HISTORY

[ ] Appendix Removal [ ] Bone Repair [ ] Cataract [ ] Colon/Partial Colon [ ] D/C [ ] Foot Surgery [ ] Gallbladder
[ ] Heart Bypass [ ] Heart Valve Replacement [ ] Hernia Repair [ ] Hip Surgery [ ] Hysterectomy
[ ] Knee Surgery [ ] Mastectomy [ ] Prostate [ ] Spleen [ ] Tonsillectomy [ ] None
[ ] Other: _____

SOCIAL HISTORY

Alcohol Use: __ Frequent __ Social __ Never __ Previous History of Alcohol use
Tobacco Use: __Smoking __ Never Smoked __ Former Smoker – Past amount _____

CURRENT MEDICATIONS/ NONE {]

Medication/Dosage	Frequency	Medication/Dosage	Frequency
Medication/Dosage	Frequency	Medication/Dosage	Frequency
Medication/Dosage	Frequency	Medication/Dosage	Frequency
Medication/Dosage	Frequency	Medication/Dosage	Frequency

PHYSICIAN NOTES

Southwest Valley Surgical Associates, PLLC
13555 W. McDowell Rd., Suite 204 Goodyear, AZ 85395-2626
Phone: (623)247-0300 Fax: (623)247-9268
Farid Zehtab, D.O. FACS **Prashant Narain, M.D. FACS** **Rama Muddaraj, M.D. FACS**

Acknowledgement of Receipt of Privacy Notice

Our Pledge

We understand that medical information about you and your health is personal. We are committed to protecting medical information in accordance with all federal and state laws. When you receive services at the practice, we create a record and need this record to provide you with quality care and to comply with certain legal requirement. This notice applies to the practice's records that are generated by your visit to the practice, whether the practice or your personal doctor makes these records.

Please list below any individuals you permit Southwest Valley Surgical Associates, PLLC. to discuss your medical care with. *i.e. family members or trusted acquaintances.*

- Name and Relationship: _____
- Name and Relationship: _____

Please list and individuals you specifically do **NOT** permit us to speak to or correspond with regarding your medical care. *i.e. Attorney's office.*

- Name and Relationship: _____
- Name and Relationship: _____

May we leave results on voicemail? (Circle one) Yes No

May we send you text messages regarding changes to your appointment or post-operative care?

(Circle one) Yes No Cell phone: _____

I understand that I have the right to amend any of the above information at any time and will otherwise remain in effect for one year.

Printed Name of Patient: _____

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of the patient Relationship (Parent, Legal guardian, etc)

Financial Responsibility Form

At Southwest Valley Surgical Associates, we strive to give you the best possible care. In order to serve this purpose, it is important that you understand the process of reimbursement. Please read this Financial Responsibility Form and sign at the bottom to acknowledge that you understand your accountability.

INSURANCE COVERAGE

It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations, as well as, authorization requirements. This information can be obtained by contacting your insurance carrier. We attempt to verify that your coverage is valid at the time of the visit. However, if your coverage is not in effect at the time of the visit, the financial responsibility for any payments due will be yours.

*****If you have had any changes in your insurance coverage you must notify us.*****

CO-PAYMENTS, CO-INSURANCES AND DEDUCTIBLES

Co-payments and co-insurances are your responsibility. Your insurance company expects us to collect them from you at the time of service. Understand that you will be expected to pay your co-payment for each and every date of service. You are responsible for your deductibles. The deductible is determined by your individual contract with your insurance carrier. We may not have information about each person's deductible amount, and how much of that has been met. You will be responsible for finding out all information about your deductible prior to your appointment with our office.

NON-COVERED SERVICES AND MEDICAL NECESSITY

All patients are responsible for payment if their insurance carrier denies payment for services rendered because they were stated as "non-covered services" or deemed as "medically unnecessary." To avoid this, please check with your insurance carrier prior to receiving any treatment.

SELF PAYMENT OR SELF-PAY

All self-pay patients are required to pay at the time service is rendered. Please be prepared to make this payment with the front desk personnel prior to the visit.

Print Name: _____ Signature: _____ Date: _____