Please circle the Physician you will be seeing today.

Julianne Santarosa, MD Donald Reed Jr, MD Gerson Pineda, MD

PATIENT NAME:____

SS#________________________________SEX:___M ___F MARITAL STATUS:_________________

DATE OF BIRTH:_____________________________________AGE:___________________________

ADDRESS:____ APT#____________________________

CITY:_______________________________STATE:__________ZIP:___________________________

HOME PHONE#__________________________CELL PHONE#_______________________________

WORK PHONE#__________________________OTHER CONTACT#____________________________

EMPLOYER:_____________________________OCCUPATION:______________________________

EMERGENCY CONTACT:____

TELE#__________________________RELATIONSHIP TO PATIENT:___________________________

REFERRING DOCTOR:________________________________ TELE#_________________________

PRIMARY DOCTOR: _________________________________ TELE#_________________________

MEDICAL INSURANCE INFORMATION

WERE YOU INJURED WHILE AT WORK?______ WHEN?___________________________________

DO YOU HAVE MEDICARE?___YES___NO MEDICARE#_____________________________________

DO YOU HAVE MEDICAID?___YES____NO MEDICAID#_____________________________________

DO YOU HAVE MEDICAL INSURANCE? YES___NO____

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS All fees for professional services rendered by North Texas Access Surgeons are charged to the patient. Each North Texas Access Surgeons is a participating provider with Medicare. We agree to accept Medicare assignment and the patient is only held liable for the 20% not covered by Medicare. As a courtesy necessary forms will be completed to help expedite health Insurance payment. However, the patient will be responsible for all fees, regardless of insurance coverage. Any insurance claim not paid by the patients insurance companies in 60 days are billed directly to the patient. The patient may then seek reimbursement from their insurance company.

Name of policy holder:_______________________________ID#_______________________________

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and Disclosure of your Protected Health Information. Your protected health information will be used by North Texas Access Surgeons or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day to day health care operations of the practice.

Notice of Privacy Practices. You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this contract.

Requesting a Restriction on the use or disclosure of your information. You may request a restriction on the use or disclosure of your protected information.

North Texas Access Surgeons may or may not agree to restrict the use or disclosure of your protected health information.

If North Texas Access Surgeons agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the consent is received will not be affected.

Revocation of Consent. You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices. North Texas Access Surgeons serves the right to modify the privacy practices outlined in this notice.

Authorization to Receive and Release Medical Records.

I ____ hereby authorize for North Texas Access Surgeons to receive and release any medical records for my proper health care treatment.

Signature

I have reviewed this consent form and give my permission to North Texas Access Surgeons to use and disclose my health information in accordance with it.

Print Name of Patient:____

Signature of Patient: _____________________________________Date_________________________

Witness:____Date:________________________

PATIENT MEDICAL HISTORY

Patient Name:________________________________

Please list all medication(s) you are currently taking (include non-prescription medication) (Please include any vitamins, herbs and / or appetite suppressants.) If additional space is needed we will provide an additional page for your convenience.

Medication and Dosage	#Times per Day	Medication and Dosage	#Times per Day

Please list all allergies (including medications, shellfish, iodine, tape, latex, etc.)

Medication	Reaction

Do you have any Physical Limitations? Yes/No Explain:___________________________________

____

Have you ever had a blood transfusion? Yes/No When? ________________________ Reaction? Yes/No

Please circle any of the following surgeries you have had and indicate date of surgery:

Tonsils______________ Eye Cataract___________ Ear_____________

Carotid(neck artery)____________ Lung_________________ Back____________

Heart: Bypass/Valve____________ Colon_________________ Colon____________

Liver_____________________ Spleen________________ Appendix_________

Aneurysm_________________ Skin Cancers___________ Burns____________

Hernia____________________ Others_________________

Have you ever Been Hospitalized for any reason besides surgery? Yes/No

Reason: ____

____

Review of Systems

Please Circle any of the Following Medical Problems you now have or have had in the past:

General

Tuberculosis Rheumatic Fever

High Blood Pressure Leg cramps

Polio Kidney Failure

Stroke Kidney Stones

Cataracts Thyroid Problems

Glaucoma Head Injury

Gallstones Blindness

Diabetes Arthritis

HIV/AIDS Depression

Hiatal Hernia Alcohol / Drug Abuse Bleeding Problem

Cancer :Type_________________________

Angina Shortness of Breath:_____ at rest ___ with Exertion

Do you wear glasses? Yes/No Reason: Reading Near-Sightedness/Far-Sightedness/other

Pulmonary

Emphysema

Pneumonia

Asthma

Blood clot in lung

Sleep apnea

Wheezing

Cardiac

Heart Attack

Coronary Artery Disease

Blood Clot in Vein

Heart Valve Disease

Blood clot in artery

GASTRO INTESTINAL

Hepatitis

Peptic Ulcer

Do any of your blood relatives(mother, father, sister, brother, child, and grandparent) have any of the following conditions? (circle all that apply)

High Blood Pressure Glaucoma Kidney Failure Heart Valve Disease

Heart Disease/Attack Stroke Tuberculosis Diabetes Epilepsy

Gout Asthma Thyroid Disease Arthritis Blood Disorders Mental Disorders

Cancer: Type____

Usual Diet ____

Do you drink Alcohol? Yes/No Beer/Wine/ Hard Liquor # of 8oz glasses per day _____

Do you now or have you ever smoked? Yes/No # of packs per day_____ #of years____

Do you use illicit drugs or abuse prescription medicines? Yes/No Type___ How often?

Do you Exercise? Yes/NO # times per week_____ #minutes each time_____

Number of Children__________ Health Status: Well/Chronic illness Number Deceased _____

Parents _____: Mother: Living/Deceased-Age:_____ Father: Living/Deceased - Age:_____

Cause of death (if known):____

Number of Brothers and sisters:__________ Health Status: Well/Chronic illness/Deceased(#___)

Pregnant?____Yes ____No Last Menstrual Cycle? __________

REVIEW OF SYSTEMS

The following questions relate to health problems you have or have had in the past. Please Circle the appropriate conditions.

1. General: Weight Loss, Weight Gain, Fatigue
2. Neurological: seizures, vertigo, previous stroke, aneurysm, hearing impairment, abnormal speech, abnormal gait, double vision, other.
3. Ophthalmologic: glaucoma, cataracts, visual impairment, other
4. Ear, Nose, Throat: snoring, hearing aids, sinus, hoarseness, nose bleeds
5. Cardiac: Ankle swelling, chest pain, dizziness, shortness of breath leg pain, palpitations, other
6. Respiratory: Coughing, shortness of breath, wheezing, other
7. Gastrointestinal: bloody or black stools, change in bowel habits, hiatal hernia, reflux esophagitis, esophageal disease, ulcers, gastritis, duodenitis, hepatitis, yellow Jaundice, other liver disease, gallstones, gallbladder disease, pancreatic disease, chronic constipation, diarrhea, diverticulosis, diverticulitis, GI bleed, Chron's, ulcerative colitis, irritable bowel, other intestinal disease
8. Endocrine/Hormonal: thyroid disease, adrenal disease, goiter, other
9. Musculoskeletal: joint pain, arthritis, muscle, weakness, fibromyalgia, fracture, gout, cramping
10. Renal/urological: prostrate disease, frequent bladder infections, impotence, hematuria, hesitary, incontinence, nocturia>1
11. Skin: psoriasis, eczema, petichiae, pigmentation, hair loss, foot ulcers, lesions, lumps, rashes, nail changes
12. Immunological: gout, rheumatoid arthritis, lupus, other
13. Infections: AIDS, hepatitis, TB, syphilis, endocarditic, other
14. Hematologic: anemia, bleeding problem, clotting problem, leukemia, other
15. Psychological: depression, anxiety, panic attacks, anorexia, bulimia, other
16. Physical disability: problems with walking, other
17. Vascular; varicose veins, aortic aneurysm
18. Malignancy: cancer, tumor, lymphoma
19. Miscellaneous: osteoporosis, congenital syndrome, Marfan's, Turner's

I have reviewed the above information with the patient.______________________(M.D./MA)

Patient health history has been reviewed by __________________________ On ___________

Physician Date