Steven H. Silverman, MD - Vascular Surgery

PLEASE PRINT - PATIENT INFORMATION

Last Name ______________________ First Name ______________________ Middle Name ______________

Date of Birth ______________ Age_____ Social Security # ____________________ Sex (Please Circle) M F

Race___________ Marital Status________ Ethnicity _____________ Preferred Language _____________

Email Address ____

Street Address____

City ____________________ State _____ Zip ___________ Home/Cell Phone ___________/___________

Occupation ____________________ Employer _______________________ Work Phone _______________

Responsible Party / Parent / Guardian (Name/Relationship)____

Emergency Contact Name________________________________ Phone Number______________________

Primary Care Physician Name _____________________________

Referring Physician Name ________________________________

Seasonal Address (if applicable) Street____

City ____________________ State __________ Zip ___________ Home Phone ______________________

INSURANCE INFORMATION – PRIMARY

Insurance Company Name _________________________________ Phone Number____________________

Claims Address____

Policy # ______________________ Group # ___________________ Subscriber _____________________

Subscriber Social Security # _________________________ Subscriber Date of Birth_____________________

Subscriber Marital Status___________________ Relationship to Subscriber____________________________

INSURANCE INFORMATION – SECONDARY

Insurance Company Name _________________________________ Phone Number____________________

Claims Address____

Policy # ______________________ Group # ___________________ Subscriber _____________________

Subscriber Social Security # _________________________ Subscriber Date of Birth_____________________

Subscriber Marital Status___________________ Relationship to Subscriber____________________________

PHARMACY

Name ____

Address ____ Phone _____________________________

Steven H. Silverman, MD - Vascular Surgery

PERMISSION FOR VERBAL COMMUNICATIONS

______________________________ ______________________
(Print name of patient) (Birth date)

______________________________ ______________________
(Street address) (City, state, zip code)

____
(Phone number)

I permit Tampa Bay Surgical Group, its' physicians, medical assistants, and other personnel ("Health Care Providers") to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care: (List family members/friends and state the person's relationship to the patient).

This authorization is limited to discussions regarding the following medical condition(s):

____

(If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care).

Name	Phone Number	Relationship
1. ______________________	____________	____________
2. ______________________	____________	____________

Release of information under this document is limited to verbal discussions with my Health Care Providers. This document does not permit release of any written health information to the individuals named above.

This authorization is limited to the following time frame from ___________ (date) to _______ (date). If no dates are indicated, this form will remain in effect for an unlimited amount of time.

If, at any time, I do not want verbal discussions to be permitted between my Health Care Providers and any of the individuals named above, I must notify my Health Care Provider by contacting the office.

Patient's Signature: ______________________________ Date: ______________

If this Release is signed by a representative on behalf of the patient, complete the following:

Representative's Name: ______________________________________

Relationship to Patient: ______________________________________

INSTRUCTIONS: Please print, sign and return to your surgeon's office.

Tampa Bay Surgical Group
Financial Policy and Assignment of Benefits

Patient Name: ______________________________

Thank you for choosing Tampa Bay Surgical Group/Dr. Silverman ________ as your health care provider. We are committed to providing you the best available medical care. Our staff will be pleased to discuss our fees and this policy with you at any time. We ask that all patients read and sign our financial policy and assignment of benefits as well as complete our Patient Information Form prior to seeing the physician. Payments for service are due at the time services are rendered. We accept cash, check, Visa, Discover and MasterCard. We will be happy to help you process your insurance claim for reimbursement. In special instances, we may accept assignment of insurance benefits. However, you must understand that:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" charges. We are, however, contracted with most local managed care plans. We will follow their guidelines for reimbursement and submission of claims for services rendered. Any contractual provider discounts will be deducted from your balance.
2. All charges are your responsibility -- whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover, or limit your coverage by design.
3. Fees for these services, along with unpaid deductibles and co-payments, are due at the end of treatment.
4. If you have a high deductible health plan, we may collect your deductible before your surgical procedure is performed.
5. If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. After all, if your insurance does not pay, you are responsible for payment.
6. If your insurance company does not pay in full within 60 days, we require you to pay the balance by cash, check, Visa, Discover or MasterCard.
7. Returned checks and balances older than 90 days are subject to collection agency placement, collection fees, and reasonable attorney's fees. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us, so that we may assist you in the management of your account.

Lifetime Authorization

I hereby assign all medical and surgical benefits allowable and otherwise payable under my current insurance policy for services rendered and authorize and direct my insurance carrier(s) to issue payment directly to Tampa Bay Surgical Group/Dr. Silverman ____. I understand that I am responsible for any amount not covered by insurance, including applicable co-payments, deductibles, non-covered services, and unauthorized services, and agree to pay in a current manner.

I understand that Tampa Bay Surgical Group/Dr. Silverman M.D./D.O. does accept assignment for Medicare and payments will be directed to Tampa Bay Surgical Group.

Should my account be referred for collection procedures, I also agree to pay reasonable attorney's fees and collection expenses.

I certify that I have read and understand the above, and as the patient, guarantor, or patient's responsible party, agree to and accept these terms.

______________________________ ______________________________

Signature of Patient/Responsible Party Date

____

Print Name/Relationship

Tampa Bay Surgical Group Authorization To Release Healthcare Information

Patient name_________________________ Dob_______________
Previous name_______________________ SS#_______________

I request and authorize____________________________________

To release healthcare information of the patient named above to:
Tampa Bay Surgical Group
Dr Steven Silverman, MD, FACS
2800 S. Tamiami Trl
Sarasota, Fl 34239
941-312-6196 fax 941-312-4718

This request and authorization applies to:

□ All healthcare information

□ Healthcare information relating to the following treatment, condition, and dates:____

□ Other:____

Definition: sexually transmitted diseases (STD) as defined by law, RCW 70. 24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

□ Yes □ No I authorize the release of the information listed above.

□ Yes □ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient signature_________________________________ Date______

Steven H. Silverman, M.D. - Vascular Surgery

Date: ______________ Name: __________________________________

Age: ____________ Birth Date: _____________ Phone: ____________

DETAILS OF YOUR PROBLEM

Why are you here to see the surgeon today?

____

____

____

Symptoms:

____

____

How long has this been going on? ______________________________

What makes the symptoms better? ______________________________

What makes the symptoms worse? ______________________________

PAST MEDICAL HISTORY (Please check Yes for all that apply)

	Yes	Year
High Blood Pressure		
If yes, how many years: _______		
Diabetes		
If yes, how many years: _______		
Controlled by (circle one): insulin / pills / diet		
Stroke		
Seizures		
If yes, how many years: _______		
Date of last seizure: _________		
Heart Problems		
Heart Attacks		
Do you get chest pain?		
If yes, what brings it on:?		
What makes it better?		
Do you use nitroglycerin?		
Atrial Fibrillation		
Lung Disease		
Emphysema		
Bronchitis		
Asthma		
Ulcers		
Kidney Disease		
Prostate Problems		
Carotid Stenosis		

	Yes	Year
Kidney Stones		
Kidney Infections		
Hepatitis		
Pancreatitis		
Jaundice		
Cancer		
Intestinal Problems		
Skin Disease		
Skin Cancer		
Sinus Problems		
Breast Problems		
Parkinsons		
Arthritis		
Thyroid Problems		
Gout		
Dentures		
Hiatus Hernia		
High Cholesterol		
Glaucoma		
Migraines		
Blood Vessel Disease		
Depression		
Blood Clots in Legs		
Anemia		

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Date: ______________ Name: __________________________________

Sleep Apnea				Parkinsons		

Please List Any Other Medical Conditions:

____

____

PAST SURGERIES

(Include all operations such as tonsillectomy, appendectomy, cataracts, C-section, etc.)

Operation	Date	Hospital/City	Surgeon
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

Did you experience any significant complications from any of these operations (circle one) ? Yes / No

If Yes, please explain:

____

____

INJURIES

Type	Year	Hospital/City
1.		
2.		
3.		

TOBACCO & ALCOHOL USE

Do you smoke? (circle one) Yes / No If Yes: Packs per day: ______________ Number of years: __________

Have you smoked in the past (circle one) Yes / No If Yes How many years ago did you quit? ________________

How many years did you smoke? ________________

How many packs per day? ____________________

Do you consume alcohol? (circle one) Yes / No If Yes, Drinks per day __________ Number of years: ________

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SURGICAL GROUP

Date: _______________ Name: ____________________________________

ALLERGIES TO MEDICATIONS

(Such as penicillin, sulfa, iodine, etc.)

Name of Medication	State the reaction that occurred
1.	
2.	
3.	
4.	

Transfusions? (circle one) Yes / No If yes, state dates ________________________________

MEDICATIONS

(Include birth control pills, water pills, hormones, aspirin, etc.)

Pharmacy Name: ________________________________ Phone: ____________________

MEDICATION	DOSE	TIMES PER DAY	ROUTE	DATE
		1 2 3 4 PRN		
		1 2 3 4 PRN		
		1 2 3 4 PRN		
		1 2 3 4 PRN		
		1 2 3 4 PRN		
		1 2 3 4 PRN		
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		1 2 3 4 PRN		

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Date: ______________ Name: __________________________________

SOCIAL HISTORY

Place of Birth: (City and State) ____

Marital Status: (circle one) Married Single Widowed Divorced Partnered

Occupation: ________________________________ If retired, previous occupation ______________________

Education: _________________________________ Hobbies: _______________________________________

Who lives with you? ____

FAMILY HISTORY

	CIRCLE ONE	AGE	MEDICAL PROBLEMS	IF DECEASED – AGE AND CAUSE OF DEATH
Father	Alive Dead			
Mother	Alive Dead			
List all brothers				
	Alive Dead			
	Alive Dead			
	Alive Dead			
	Alive Dead			
	Alive Dead			
List all sisters				
	Alive Dead			
	Alive Dead			
	Alive Dead			
	Alive Dead			
	Alive Dead			
List all sons				
	Alive Dead			
	Alive Dead			
	Alive Dead			
	Alive Dead			
	Alive Dead			
List all daughters				
	Alive Dead			
	Alive Dead			
	Alive Dead			
	Alive Dead			
	Alive Dead			

FEMALES – GYNECOLOGICAL HISTORY

Number of pregnancies: _______________ Number of miscarriages: _______________________

Do you use Birth Control pills: (circle one) Yes No Date of last menstrual period: ____________________

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Date: ______________ Name: __________________________________

PLEASE MARK ANY OF THE BELOW SYMPTOMS THAT YOU HAVE EXPERIENCED IN THE LAST 3 MONTHS

REVIEW OF HEALTH (CHECK ALL THAT APPLY)					
CONSTITUTIONAL		**VASCULAR**		**NEURO/PSYCH**	
Change in appetite		Leg cramps while walking		Dizziness	
Weight loss		Foot pain while lying down		Loss of strength in arms or legs	
Weight gain		Numbness of extremity		Loss of sensation in arms or legs	
Fever		Varicose veins		Loss of vision in one eye	
Chills		Blood clots		Headache	
Lethargy		Leg or foot wounds		Loss of consciousness	
Weakness		Leg cramps at night		Seizures	
				Speech changes	
HEENT		**GI**		Memory impairment	
Headache		Abdominal pain		Depression	
Visual loss		Blood in stool		Anxiety	
Hearing loss		Constipation			
Dizziness		Diarrhea		**DERMATOLOGIC**	
Nose bleeds		Difficulty swallowing		Itching	
Difficulty swallowing		Heartburn		Rash	
		Vomiting blood		Change in mole	
RESPIRATORY		Yellow skin		Skin Leison	
Cough		Tarry stool			
Shortness of breath with exertion		Nausea		**MUSCULAR / SKELETAL**	
Shortness of breath at rest		Vomiting		Back pain	
Wheezing				Joint pain	
		GU		Muscle aches	
CARDIOVASCULAR		Decreased stream		Neck pain	
Chest pain		Painful urine			
Palpitations		Bloody urine		**HEMATOLOGIC**	
Leg swelling		Urinary incontinence		Easy bleeding	
Difficulty sleeping flat		Night time urination		Easy bruising	
Passing out				Enlarged lymph nodes	
Chest pressure		**METABOLIC / ENDOCRINE**		Blood clots	
		Generalized weakness			
REPRODUCTIVE		Goiter (enlarged thyroid)		**IMMUNOLOGIC**	
Post menopausal		Weight gain		Hives	
Hormone replacement		Weight loss		Asthma	
				Contact dermatitis (Rash)	

PLEASE INITIAL ______________