7001 HODGSON MEMORIAL DR. SUITE 1

SAVANNAH, GEORGIA 31406
912-354-6303

PATIENT & HISTORY FORM INFORMATION

MARITAL STATUS: S W D M (circle one) AGE ____________

NAME ______________________________DATE OF BIRTH________________

ADDRESS __________________________________ SS# ____________________

MAILING ADDRESS ____

CITY______________________ STATE ________________ ZIP ___________

HOME PHONE ____________________ CELL PHONE __________________

EMPLOYER _________________________ OCCUPATION __________________
WORK NUMBER ______________________________

SPOUSE/GUARDIAN _______________________ RELATION_____________

SPOUSE'S SS# __________________EMPLOYER___________________________

SPOUSES'S DOB__________________

EMPLOYERS ADDRESS ____________________________PHONE ___________

EMERGENCY CONTACTS
____PHONE_________________
MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE? ________

PRIMARY CARE PHYSICIAN__________________PHONE_________________
GASTROENTEROLOGIST____________________PHONE_________________
GYNECOLOGIST ___________________________ PHONE_________________
CARDIOLOGIST ___________________________PHONE_________________

WHO REFERRED YOU FOR THIS PROBLEM?
DOCTOR'S
NAME_____________________________PHONE__________________________

ADDRESS ____

PATIENT NAME:____DOB_____________

INSURANCE INFORMATION:

PRIMARY INSURANCE:____

ADDRESS ____

PHONE _________________________ID#____________________________GROUP#___________________

INSUREDS NAME________________________________EMPLOYER______________________________

SECONDARY INSURANCE: ____

ADDRESS____

PHONE _________________________ID#____________________________GROUP#___________________

INSUREDS NAME___________________________________EMPLOYER____________________________

IS THIS WORK RELEATED (Workers Comp)? ________________

SURGERIES & HOSPITALIZATION, DATE AND DOCTOR:_

____ ____

____ ____

____ ____

____ ____

____ ____

HAVE YOU EVER HAD A PROBLEM WITH ANESTHESIA? YES NO (circle one)

ALLERGIES TO MEDICATION, LATEX, OR FOOD: ____

____

CURRENT MEDICATION: DOSE FREQUENCY

____

____

____

____

____

____

DO YOU TAKE ASPRIN OR ANY OTHER BLOOD THINNERS? _________________

DO YOU ACCEPT BLOOD PRODUCTS (IN CASE OF LOSS OF BLOOD)_____YES ____NO

NAME____DATE_______________
DATE OF BIRTH____________________

REVIEW OF SYSTEMS

Are you currently, or have you had, problem with:

Constitutional	Circle One
Fever	Yes No
Weight Loss	Yes No
Excessive Fatigue	Yes No
Night Sweats	Yes No
Eyes	
Wear Glasses	Yes No
Infections	Yes No
Injuries	Yes No
Glaucoma	Yes No
Cataracts	Yes No
Ear, Nose, Throat and Mouth	
Wear Hearing Aids	Yes No
Hearing Loss	Yes No
Trouble with Balance	Yes No
Nose Bleeds	Yes No
Cardiovascular	
Chest Pain or Angina	Yes No
High Blood Pressure	Yes No
Irregular Pulse	Yes No
Heart Murmur	Yes No
Pacemaker	Yes No
History of Phlebitis	Yes No
Respiratory	
Asthma	Yes No
Chronic Cough	Yes No
Emphysema	Yes No
Shortness of Breath	Yes No
Bronchitis	Yes No
Pneumonia	Yes No
Lung Cancer	Yes No
Bloody Sputum	Yes No
Gastrointestinal	
Indigestion or Pain With Eating	Yes No
Nausea	Yes No
Vomiting	Yes No
Blood in Your Vomit	Yes No

NAME____DATE_______________

Liver Disease	Yes	No
Jaundice	Yes	No
Change in Bowel Habits	Yes	No
Colon Cancer	Yes	No
Blood in Stool	Yes	No
History of Hepatitis	Yes	No
Urinary		
Urinary Tract Infection	Yes	No
Difficulty Starting or Stopping Stream	Yes	No
Incontinence	Yes	No
Kidney Stones	Yes	No
Prostate Cancer (males)	Yes	No
Endometriosis (females)	Yes	No
Uterine or Cervical Cancer (females)	Yes	No
Passage of Air in Urine	Yes	No
Skeletal		
Back Pain	Yes	No
Arm or Leg Pain	Yes	No
Joint Pain or Swelling	Yes	No
Integumentary		
Skin Disease	Yes	No
Do you form keloid after surgery?	Yes	No
Skin Cancer	Yes	No
Breast Pain, Tenderness or Swelling	Yes	No
Nipple Discharge	Yes	No
Date and Result of Last Mammogram ________________________________		
Neurological		
Fainting Spells or Blacking Out	Yes	No
Seizures	Yes	No
History of stroke	Yes	No
Psychiatric		
Anxiety	Yes	No
Depression	Yes	No
Other Psychiatric Disorder/Treatment ______________________	Yes	No

NAME____DATE___________

Endocrine

Diabetes	Yes	No
Thyroid Disease	Yes	No
Recent use of Cortisone or Predisone	Yes	No
Hormone Problems	Yes	No

Hematologic/Lymphatic

Anemia	Yes	No
Hemophilia	Yes	No
Bleeding Tendencies	Yes	No
Blood Transfusion	Yes	No

If yes, when? ____

Allergic/Immunologic

Immunologic Disorders	Yes	No
Aids or tested positive for HIV status______________	Yes	No
Exposure to aids or someone HIV positive	Yes	No

Social History

Who lives at home with you?____

Occupation?____

Do you smoke? Yes No How many cigarettes per day?_______How long__________

Do you drink alcohol? Yes No How much___________ How often?_____________

FAMILY HISTORY	ALIVE	DECEASED	AGE	HEALTH STATUS/CAUSE OF DEATH
Father	A	D		
Mother	A	D		
Brother/Sister	A	D		
	A	D		
	A	D		
	A	D		

The above information is accurate to the best of my knowledge.

Patient Signature____________________________ Date _______________

I have reviewed the above information with the patient.

Signature _____________________________ Date ________________

Patients Rights and Responsibilities

To better educate you of your rights and responsibilities we have written this policy for you. If you have any questions about what is written in this policy please speak with the office manager or collection manager. Our practice is dedicated to giving you the best possible care and to assist with any problems that may arise during your treatment, and for you to completely understand your rights and responsibilities and how they are an essential part of your care and treatment.

Responsibilities To You:

All Patients have a right to:

- Confidentiality of records and know that they will only be shared with the hospitals and doctors that are participating in your treatment.
- To refuse treatment of your illness and be informed by this physician of the consequences of that decision.
- To an estimate of the charges for the services that you will receive and to know how we expect you to take care of that expense.
- To let us know of your concerns or complaints concerning this office and for you to be able to address these with the appropriate people in our office.

Patients Responsibilities To This Office:

- You are responsible for your account being kept current;balance must be taken care of in a timely fashion. Your insurance policy is a contract between you and and your insurance company. If your account should be sent to a collection agency you will be responsible for all associated FEES as well as the balance.
- We will file your insurance as a courtesy to you and will assign payment to be sent to this office. If your insurance company doesn't pay within a reasonable length of time (90 days), we will then turn to you for payment. We do participate with a number of insurance companies, and if your company is one we will file your claim and comply with the guidelines of that company. Co-payments must be paid at the time of visits.

Rights and Responsibilities

- If we do not participate with your insurance company we will file the claim for you. If the insurance company does not pay the claim or pays benefits to you, you are then responsible for the balance in full. If you do not have insurance coverage, payment arrangement must be made for any charges or must be paid at the time of service.
- We will be happy to set up payment arrangements if requested. Statements are mailed monthly and are due upon receipt, unless insurance is pending.
- In the event of surgery we will obtain any pre-certification that is required by your insurance company. BUT you are responsible for obtaining referral numbers for any office visits and must be presented prior to being seen by the physician.
- In some surgical cases in addition to the physicians charges there will be a charge for the physician assistant who aids the physician in your treatment.
- Parents and or guardians will be responsible for services rendered to minor patients that are treated.
- When appointments are scheduled you are responsible for bringing the
  X-RAY FILMS and RECORDS pertinent to your problem you are being seen for.

AUTO ACCIDENTS/OTHER ACCIDENTS
SouthCoast Health cannot be expected to wait for the conclusion of long-tern court cases or settlement of a disputed insurance claim before being paid. The staff will be glad to file all insurance. If your insurance company denies any charges, it will immediately become your responsibility.
WORKER'S COMPENSATION
Patients who are injured on the job should report the injury directly to their employer. The employer will be responsible for directing the employee to a doctor who is listed on their PANEL OF PHYSICIANS. Before we will be able to see you as a patient, we will require you to fax or bring a letter verifying that your employer will accept responsibility for services rendered. The staff has been instructed to reschedule all workers' compensation patients that are unable to provide us with the information requested.
MEDICAID
Please bring a copy of your Medicaid card to each visit: otherwise we will have to bill you directly. You will be responsible for all services not covered by Medicaid. This will include certain supplies and any office visits made after your authorization has expired.
AUTHORIZATION FOR SERVICES
The signature below serves as authorization for services rendered by SouthCoast Health for the below named patient, and provides release of information necessary to file insurance and assign benefits otherwise payable to policy holder to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by the insurance carrier—a copy of the signature is valid as the original.
AUTHORIZATION: RELEASE OF INFORMATION
The signature below serves as authorization for SouthCoast Health to release or receive medical information for the purpose of patient referral. A copy of this signature is as valid as original.

This certifies that I have read and understand the PATIENT RIGHTS and RESPONSIBILITIES of SOUTHCOAST HEALTH SURGERY and agree to abide by its terms and know it is in compliance with HIPPA and the OFFICE OF THE ATTORNEY GENERAL.

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Signature of Patient or Guardian Date

NOTE: Copy available upon request.