ROYAL OAK SURGICAL ASSOCIATES, P.C.

Robert P. Jury, M.D., F.A.C.S.

Peter F. Czako, M.D., F.A.C.S. Beaumont Medical Building, Suite 205

Kevin R. Krause, M.D., F.A.C.S. 3535 West 13 Mile Road

Julie A. Koffron, M.D., F.A.C.S. Royal Oak, Michigan 48073

Sapna Nagar, M.D. Phone: (248) 551-8180 Fax: (248) 551-8181

General, Laparoscopic and Endocrine Surgery

**PLEASE COMPLETE PAPERWORK (FRONT AND BACK) AND BRING WITH YOU ON THE DAY OF YOUR APPOINTMENT.**

Thank you for choosing our office. In order to serve you properly, we will need the following information:

(Please Print). All information will be strictly confidential.

Patient’s Name: ­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Today's date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Male\_\_\_\_\_\_\_\_\_\_\_Female\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Single\_\_\_\_\_\_\_\_\_\_\_\_Married\_\_\_\_\_\_\_\_\_\_Widowed\_\_\_\_\_\_\_\_\_\_\_Divorced\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 City State Zip

Home Phone Number: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Buisness Phone Number: (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Social Security\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: African American\_\_\_\_\_American Indian\_\_\_\_\_Asian\_\_\_\_\_Caucasian\_\_\_\_\_

 Native Hawaiian/Pacific Islander\_\_\_\_\_Other\_\_\_\_\_

Ethnicity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred Language:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you need an interpreter: Y\_\_\_\_ N\_\_\_\_\_\_

Name of Spouse:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s** Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE GIVE PECEPTIONIST INSURACNE CARD AND LICENSE TO COPY

I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION NECESSARY TO EXPEDITE INSURANCE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE. FURTHERMORE, I AUTHORIZE THIS OFFICE TO RELATE OUR EVALUATION TO OTHER PHYSICIANS PROVIDING CARE TO ME THAT WILL ENHANCE CONTINUITY OF CARE.

**Patient or Guardian Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAPERWORK COMPLETED BY PATIENT (please initial)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Medical History (please circle response for each question)

|  |  |
| --- | --- |
| DiabetesY or N | If yes, please answer questions belowInsulin Y or N Neuropathy Y or N Retinopathy Y or N Diabetic pills Y or N Nephropathy Y or N |
| High blood pressure | Y or N | Hepatitis | Y or N |
| High cholesterol | Y or N | Liver disease | Y or N |
| Cancer (list type) | Y or N | Headache (list type) | Y or N |
| High triglycerides | Y or N | Asthma | Y or N |
| Obstructive sleep apneaSnoringC.Pap/BiPap | Y or N | Psychiatric hospitalizations | Y or N |
| Joint pain (circle areas)Low back, hip, knee, ankleFoot, hands, shoulder, other. | Y or N | Bowel disease (colitis, irritableBowel, etc.) | Y or N |
| Depression | Y or N | Kidney disease | Y or N |
| Heartburn/reflux | Y or N | Kidney stones | Y or N |
| Hiatal hernia | Y or N | Seizures | Y or N |
| Heart attack | Y or N | Skin disorder | Y or N |
| Heart failure | Y or N | Stroke | Y or N |
| Irregular heart rate | Y or N | Ulcers | Y or N |
| Chest pain or angina | Y or N | TB | Y or N |
| Bladder incontinence | Y or N | Hypoglycemia | Y or N |
| Leg/ankle swelling | Y or N | Varicose veins | Y or N |
| Blood clot or phlebitis (DVT) | Y or N | Gout | Y or N |
| Pulmonary embolus (blood clotIn lung) | Y or N | Rheumatic fever | Y or N |
| Gallstones or gallbladder problems | Y or N | Blood in stool | Y or N |
| Shortness of breath with activity | Y or N | Crohn’s disease | Y or N |
| Anemia | Y or N | Ulcerative colitis | Y or N |
| Anesthetic reaction | Y or N | Obesity | Y or N |
| Bleeding problem | Y or N | Glaucoma | Y or N |
| COPD/emphysema | Y or N | Home oxygen | Y or N |
| Diarrhea | Y or N | Constipation | Y or N |

Please list any other medical conditions not listed above

With respect to each and every operation which you have undergone, please provide the following information.

|  |  |  |
| --- | --- | --- |
| Operation | Date | Problems/Complications (if any) |
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**Past Non-Surgical Hospitalizations**

Please list all previous major non-surgical hospitalizations.

|  |  |  |
| --- | --- | --- |
| Problem | Date | Location/Hospital |
|  |  |  |
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***HISTORY OF FALLING:***

***Have you had 2 or more falls in the past year or a fall with injury in the past year?***

***Y N***

**PHARMACY NAME:**

Address:

Phone Number:

Fax Number:

**Cardiac Procedure History:**

Have you had a EKG?

If yes, when?

Have you had a STRESS TEST?

If yes, when?

have you had a CARDIAC CATHETERIZATION?

If yes, when?

**Medication History**

Please list current medications, including dosage and frequency.

Prescription Drugs

|  |  |  |
| --- | --- | --- |
| Name | Dose | Frequency |
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Over-the-Counter Medications/Vitamins

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Have you ever had a reaction to any of the following: If yes, please explain:

Milk/Dairy Products Y N

Eggs Y N

Shellfish Y N

**Medication Allergies**

Are you allergic to any medications?  Yes  No

If so, please provide the following information concerning each and every medication to which you are allergic.

|  |  |
| --- | --- |
| Name of Medication | Type of Reaction |
|  |  |
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| --- | --- | --- |
| Are you allergic to Latex? |  Yes |  No |
| Are you allergic to Iodine Dye? |  Yes |  No |

**~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~**

**WOMEN:**

Number of pregnancies:

Number of live births:

Patient Name: Date

**Please circle Yes or No:** Do you have a Advanced Directive/Living Will: Y or N

**Emergency Contact Information:**

Name: Relationship:

Home Phone: Cell Phone:

Name: Relationship:

Home Phone: Cell Phone:

PRIMARY CARE PHYSICIAN INFORMATION

|  |  |
| --- | --- |
| Primary Care Physician’s Name: |  |
| Address (if known) |  |
| Telephone Number (if known) |  |
| Hospital doctor is affiliated with: |  |

REFERRING PHYSICIAN INFORMATION

|  |  |
| --- | --- |
| Referring Physician’s Name: |  |
| Address (if known) |  |

ENDOCRINOLOGIST (if applies)

|  |  |
| --- | --- |
| Endocrinologist's Name: |  |
| Address (if known) |  |

Please list all other medical doctors with which you are currently being tre

|  |  |
| --- | --- |
| PHYSICIAN NAME: | SPECIALTY: |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

Patient Name: Date:

**PAIN ASSESSMENT (please circle) regarding the reason for your visit with our office.**



|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| No Hurt | Hurts Little | Hurts Little | Hurts Even | Hurts Whole | Hurts |
| 0 | Bit2 | More4 | More6 | Lot8 | Worst10 |

**Location of pain:**

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

**Family History:** Has anyone in your family had any of the following?  **If YES, please state which family member.**

relationship

|  |  |  |  |
| --- | --- | --- | --- |
| High blood pressure | Y | N |   |
| High cholesterol | Y | N |   |
| Heart disease | Y | N |   |
| Stroke | Y | N |   |
| Diabetes | Y | N |   |
| Cancer (list types) |  |  |  |
| Bleeding disorders | Y | N |  |
| Blood clots | Y | N |  |

Patient Name: Date

**Alcohol, Tobacco and Drug Consumption**

***Alcohol:***

How often do you drink alcohol?

 Never  Rarely (2 times per month or less)  Occasionally (twice per week or less)

 Daily (at least once per day)

If you indicated above that you drink “daily”, please state: How many times per day?

What type of alcoholic drink?

Have you ever participated in an alcohol or drug rehabilitation program?

 Yes  No

***Tobacco:***

Do you presently smoke tobacco?  Yes  No

If yes:

How many packs per day?

Have you ever smoked tobacco?  Yes  No

If yes:

How many packs per day? For how many years? When did you quit?

Do you presently use smokeless tobacco?  Yes  No

If yes:  Snuff  Chew

Have you ever used smokeless tobacco?  Yes  No

If yes:

When did you quit?

***Drug Consumption:***

Do you currently use illicit drugs?  Yes  No

If yes, what type of drugs do you currently use?

How often do you use illicit drugs?

Have you ever used illicit drugs?  Yes  No

When was the last time you used illicit drugs? What type of illicit drugs? How often?

PATIENT NAME:

**PLEASE CHECK ALL CURRENT SYMPTOMS.**

DATE:

REVIEW OF SYSTEMS SHEET

CONSTITUTIONAL CARDIOVASCULAR

Fever Chills

Weight Loss Fatigue

Sweats Weakness

Chest pain Palpitations Shortness of breath Claudication

Leg swelling

RESPIRATORY:

SKIN Cough

Rash Itching Jaundice

Shortness of breath Wheezing

GASTROINTESTINAL

HENT: Heartburn

Headaches Hearing loss Ringing in ears Ear pain Nosebleeds Congestion Sore throat

Nausea Vomiting Abdominal pain Diarrhea Constipation Blood in stool

GENITOURINARY

EYES: Pain or burning

Blurred vision Double vision Photophobia

Urgency Frequency Blood in urine

MUSCULOSKELETAL PSYCHIATRIC

Myalgias Neck pain Back pain Joint pain Falls

Depression Suicidal ideas Substance abuse Hallucinations Nervous/anxious Insomnia

NEUROLOGICAL Memory loss Dizziness

Tingling

Tremor Sensory change Speech change Focal weakness Seizures

ENDOCRINE

Appetite changes Cold intolerance Increased thirst Increased urination Hair changes

HEMATOLOGY

Easy bruising

Enlarged lymph nodes

Prolonged bleeding

**COMPLETION OF THIS FORM ALLOWS US TO SPEAK WITH PEOPLE LISTED IN #2.**

**AUTHORIZATION TO RELEASE MEDICAL RECORDS AND**

**INFORMATION WAIVER OF PRIVACY**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The undersigned, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whose address is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_states:

1. **Authorization.** You are authorized to do the following:
	1. Disclose any and all information regarding my past and current medical treatment and care;
	2. Provide copies of all documents and records in your possession regarding my medical condition and treatment at any time, including medical history and findings, consultations, prescriptions, treatments, x-rays, radiology reports, special consultation reports, diagnosis and prognosis, copies of all hospital, medical and billing records.
2. **Provide Information To.** The information identified in this document may be released, provided to, or discussed with any of the following persons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **When to Provide Information.** You are authorized to provide the information identified in this

document at the request of the individual or individuals identified in paragraph 2 above.

1. **Expiration.** This Authorization contains no expiration date.
2. **Authority to Revoke.** The undersigned reserves the right to revoke this authorization. In order to revoke this authorization, the notification must be written, signed by the undersigned, and dated. The revocation will then become effective upon delivery to you.
3. **Redisclosure.** I understand that the information disclosed by reason of this document may be subject to re-disclosure by the recipient and therefore may no longer be protected under state or federal law.
4. **Photostatic Copies.** A photostatic copy of this Authorization shall be considered as effective and valid as the original.
5. **Voluntary Action.** I understand that I am not required to sign this document and I am signing this document voluntarily.
6. **Privacy Waiver.** With regard to the disclosure of information authorized in this document, I waive any right of privacy that I may have under the authority of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA), any amendment or successor to that Act, or any similar state or federal act, rule or regulation that might otherwise prevent any health care provider from providing access to my medical records under this document, and I hold harmless from any claim of liability under such act, rule or regulation, any medical provider who provides access to my medical information and records under this document.
7. **Durable Power.** This power of attorney shall not be affected by my disability. The authority of my agent shall be exercisable notwithstanding my later disability or incapacity or later uncertainty as to whether I am alive.

Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature

PREPARED BY FERGUSON & WIDMAYER, P.C.

538 North Division \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ann Arbor, Michigan 48104 Print Name

734-662-0222

**PLEASE COMPLETE NAME, ADDRESS, #2, DATE AND SIGN**

**NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT**

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose you record to others unless you direct us to do so or unless the law authorizes or pommels us to do so. You may see you record or get more information about it by contacting [name or title of Privacy Officer].

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access you information.

**By my signature below I acknowledge receipt of the Notice of Privacy Practices.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or legally authorized individual signature Date Time

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name if signed on behalf of the patient Relationship

 parent, legal guardian, personal representative

**PLEASE SIGN AND DATE**

**PLEASE OBTAIN A PRIVACY POLICY PACKET IN ROYAL OAK SURGICAL ASSOCIATES LOBBY.**

Royal Oak Surgical Associates, P.C.

3535 W. 13 Mile Rd.

Suite 205

Royal Oak, Michigan 48073

Phone: 248-551-8180

Fax: 248-551-8181

**Patient Financial Policy**

Royal Oak Surgical Associates PC, have implemented the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and treatment to you. Your understanding of your financial responsibilities is an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, payment is due at the time of service for any copays, coinsurance, deductibles or previous balances. For your convenience we accept Cash, Check, Visa, Mastercard, Discover and American Express.

**Your Insurance**

We have made prior arrangements with many insurance plans to accept an assignment of benefits. Your healthcare policy contract is between you and your insurance company which you or your employer

has agreed upon. You may be required to pay for deductibles, copays, co-insurance, or cost share amounts.

If you are enrolled in a HMO and require a referral, you are responsible for providing that information. Failure to provide proper authorization will require the patient to reschedule their appointment or pay for services rendered.

In the event that your health plan determines a service to be “not covered,” you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I

also understand and agree that the practice may amend such terms from time to time. Printed Name of the Patient

Signature of Patient or Responsible Party if a Minor Date