Montrose Surgical Associates

PATIENT REGISTRATION FORM

(Confidential)

Please Print (Please complete the Health History Questionnaire, too)

Primary Doctor_____ReferringDoctor_____

Patient Name_____ Birth Date___/____/_____
First M.I. Last MM DD YYYY

Social Security # _____ **Email**_____

Race: White/Other/Asian/Black-African Am/Am Indian/ Hawaiian-Alaskan Nat/Hawaiian-Other Pacific Island

Ethnicity: Hispanic-Latino/ Non-Hispanic-Latino/Unknown

Language: English/Spanish/French/German/ Italian/Portugese/ Japanese/Russian

If minor, name (address if different) & SS# of parent /guardian_____

_____

Mailing Address_____
Street or box number City State Zip

Home Phone_____ Cell Number_____

Employer_____ Position _____ Work Phone_____

Spouse Name_____ Spouse SS#_____Spouse DOB___/___/___

Emergency Contact_____Telephone_____
(Not Living w/ You) Name Relationship

Insurance:_____NONE **How did you hear about us?** _____

____Medicare ____RMHMO ____Comp WORK RELATED:___Y___N Date___/____/___

____Medicaid ____BCBS ____Other AUTO ACCIDENT___Y___N Date___/___/____

INSURED PATIENTS: ASSIGNMENTS OF BENEFITS AND RELEASE OF INFORMATION:
Until further notice, I authorize payment of Medicare benefits and/or any other insurance benefits be made on my behalf to Montrose Surgical Associates, P.C. for any services furnished to me by them. I authorize the release of any information necessary to determine or to process claims.

Signature_____ **Date**_____

ALL PATIENTS:
I authorize Montrose Surgical Associates to give me reasonable and proper medical care by today's standards. I understand and agree that, regardless on my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered and any legal fee incurred to collect this bill. We maintain the right to issue a No Show Fee of $20.00, please cancel within 24 hours of your appointment. I have received and read a copy of this office's financial policy. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge.

Signature_____ **Date**_____

Montrose Surgical Associates

Initial Patient Questionnaire and Update

My Name is: _____

My Date of Birth is: _____

My PCP is: _____ Today's Date is: _____

I am seeing the surgeon today for: _____

MD use

I have had the following surgeries: (Past Surgical History)

_____ _____

_____ _____

_____ _____

I am currently being treated for: (Past Medical History)

_____ _____

_____ _____

_____ _____

I smoke cigarettes

□ Yes I smoke _____ packs per day

□ No I have smoked for ____years

I drink alcohol

□ Yes _____ drinks per week

□ No

My Family has experienced the following medical problems: (Family History)

Mother	Father
Sisters	Brothers
Daughters	Sons

My Last Colonoscopy was in _____ at _____

The Doctor found: □ Nothing □ Polyps □ Cancer

I, or my immediate family members have a problem with:

□ Anesthesia □ Bleeding Problems

Montrose Surgical Associates

Initial Patient Questionnaire and Update

My Name is: _____

My Date of Birth is: _____

Medication and Allergy List

I have Allergies to:

□ Latex
□ IV Contrast/Dye
□ Food
□ the Environment
□ Medications

Allergies to which ones?

_____
_____
_____
_____
_____

I take the following Medications or Supplements:

NAME:	How much? (mcg,mg,grams etc:)	How often? (once or twice a day, once a week, etc:)

Montrose Surgical Associates

Initial Patient Questionnaire and Update

My Name is: _____

My Date of Birth is: _____

Additional Information:

Acknowledgement of Receipt of Notice

I hereby acknowledge that a copy of this medical practices Notice of Privacy Practices was made available to me by Montrose Surgical Associates.

I understand that I may request a revised copy of this medical practices Notice of Privacy Practices at any time should there be any subsequent changes.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate:

Relationship:

- ☐ **Parent or Guardian of minor patient**
- ☐ **Guardian or conservator of an incompetent patient**
- ☐ **Beneficiary or Personal Representative of deceased patient**

Name of Patient _____

For Office Use Only:

Signed form received by: _____

Acknowledgement refused:

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

_____

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