

Associates in
GENERAL & VASCULAR SURGERY

Vincent J. Belcastro, M.D., F.A.C.S.
Charles C. Boggs, M.D.
Thad C. Kammerlocher, M.D., F.A.C.S.
Michelle D. Mon, M.D., F.A.C.S.

 A Division of 21st Century Oncology, LLC

Dan Beifelschies, PA.-C.

Lea M. Blackwell, M.D.
Thomas Carrasquillo, M.D., F.A.C.S.
Thomas E. Kowalsky, M.D., F.A.C.S.
Peggy Kalkounos, D.O.

NEW PATIENT REGISTRATION

PATIENT'S LAST NAME _____ FIRST _____ MI _____

Purpose of Visit: _____

Is it Work Related? Y / N Give Date & Description _____

If Work Related, we must have a notice of Injury _____

LAST NAME OF PATIENT (If Minor, Give Parent's Info)		FIRST	MI
PERMANENT ADDRESS			MARITAL STATUS
CITY	STATE	ZIP	SEX
HOME PHONE ()	CELL PHONE ()	DATE OF BIRTH / /	
SOCIAL SECURITY NO.	RESPONSIBLE PARTY IS PATIENT <input type="checkbox"/> YES <input type="checkbox"/> NO HAS BEEN PATIENT <input type="checkbox"/> YES <input type="checkbox"/> NO	TODAY'S DATE / /	AGE
EMPLOYED BY	ADDRESS		
CITY	STATE	ZIP	TELEPHONE
OCCUPATION			

EMAIL ADDRESS		
ALTERNATE ADDRESS		
CITY	STATE	ZIP
MINOR'S LAST NAME	FIRST NAME	
DATE OF BIRTH / /	SEX	RELATIONSHIP
SOCIAL SECURITY NO. - -	PHONE () -	SCHOOL
ADDRESS		
CITY	STATE	ZIP

REFERRED BY CHECK HERE IF REFERRED BY DOCTOR

PHYSICIAN	ADDRESS	TELEPHONE ()
PATIENT REFERRAL	ADDRESS	TELEPHONE ()
		<input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> RADIO <input type="checkbox"/> NEWSPAPERS <input type="checkbox"/> OTHER

NEAREST RELATIVE NOT LIVING AT ABOVE ADDRESS

LAST NAME	FIRST	MI	ADDRESS	TELEPHONE ()	PHARMACY
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INSURANCE

NAME OF PRIMARY INSURANCE COMPANY			
ADDRESS			
CITY	STATE	ZIP	TELEPHONE ()
<input type="checkbox"/> CHECK HERE IF THE RESPONSIBLE PARTY IS THE INSURED PARTY. IF NOT, COMPLETE BELOW.	POLICY NO.	GROUP NO.	
INCLUDE NAME & ADDRESS OF INSURED PARTY	D.O.B.	SEX	RELATIONSHIP TO PATIENT

NAME OF SECONDARY INSURANCE COMPANY			
ADDRESS			
CITY	STATE	ZIP	TELEPHONE ()
<input type="checkbox"/> CHECK HERE IF THE RESPONSIBLE PARTY IS THE INSURED PARTY. IF NOT, COMPLETE BELOW.	POLICY NO.	GROUP NO.	
INCLUDE NAME & ADDRESS OF INSURED PARTY	D.O.B.	SEX	RELATIONSHIP TO PATIENT

ATTENTION:

You are responsible for getting authorizations for this visit or any visits resulting from visits here, as well as knowing the facilities (labs, hospitals, x-ray) required by your insurance.

READ IMPORTANT INFORMATION AND MEDICAL RELEASES ON REVERSE SIDE.

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NAME _____ AGE _____

Other physicians treating you and reason: _____

Allergies: _____

PAST SURGERIES
LIST TYPE OF SURGERY AND APPROXIMATE DATE:

MEDICAL HISTORY	
PLEASE CHECK ONLY THOSE CONDITIONS YOU HAVE HAD:	
	DIABETES
	HEART DISEASE
	KIDNEY DISEASE
	HIGH BLOOD PRESSURE
	CANCER
	OTHER

PRESENT MEDICATIONS			
NAME	DOSAGE/FREQUENCY	NAME	DOSAGE/FREQUENCY

FAMILY HISTORY • IF DECEASED, GIVE CAUSE OF DEATH			
CHILDREN #	LIVING _____	DECEASED _____	_____
MOTHER	LIVING _____	DECEASED _____	_____
FATHER	LIVING _____	DECEASED _____	_____
SISTERS #	LIVING _____	DECEASED _____	_____
BROTHERS #	LIVING _____	DECEASED _____	_____

SOCIAL HISTORY	
SMOKE _____ PACKS / DAY	ALCOHOL _____
QUIT _____ YEARS AGO	SIGNATURE _____

Please Read & Sign Back

SYSTEM REVIEW

CONSTITUTIONAL

Good general health lately Recent weight change Frequent fever Fatigue Other_____

EYES

Sensitive to lights Changes in vision Wear glasses/contact lenses Other_____

EARS / NOSE / MOUTH / THROAT

Hearing loss or ringing Earaches or drainage Nasal stuffiness/sneezing Frequent nosebleeds
 Mouth sores Sore throat or voice changes Swelling in neck Chewing/swallowing difficulty
 Other_____

CARDIOVASCULAR

Low exercise tolerance Chest pain or angina pectoris Rapid heartbeats/skipped beats
 Shortness of breath with activity or lying flat Swelling of feet, ankles or hands Other_____

RESPIRATORY

Chronic or frequent coughs Coughing up blood Wheezing Other_____

GASTROINTESTINAL

Loss of appetite Nausea or vomiting Abdominal pain or heartburn Change in bowel habits
 Regular use of laxatives Rectal bleeding or blood in stool Other_____

GENITOURINARY

Frequent burning/painful urination Blood in urine Change in force of stream when urinating
 Incontinence or dribbling Male - penile discharge or soreness Male - testicle pain or lumps
 Sexual difficulty Female - irregular periods Female - vaginal discharge
 Female - # of pregnancies_____ Female - # of miscarriages_____ Other_____

MUSCULOSKELETAL

Joint pain/stiffness/swelling Weakness of muscles or joints Muscle pain or cramps Back pain
 Other_____

INTEGUMENTARY

Rash or itching Change in moles Breast pain/lump/discharge Other_____

NEUROLOGICAL

Frequent or recurring headaches Light-headedness or dizziness Convulsions or seizures
 Tremors Speech problems Balance problems Memory loss or confusion Numbness or tingling sensations
 Other_____

PSYCHIATRIC

Nervousness or anxiety Sleep poorly Often depressed Change in moods
 Lifestyle change (divorce, death, loss of job) Considered/attempted suicide Other_____

ENDOCRINE

Night sweats Excessive thirst or urination Heat or cold intolerance Skin becoming drier
 Other_____

HEMATOLOGICAL / LYMPHATIC

Slow to heal after cuts Bleed or bruise easily Past transfusion Enlarged glands
 Other_____

ALLERGIC - IMMUNOLOGIC

Frequent infections/colds Chemotherapy X-Ray treatments Other_____

Name_____ DOB_____ Date_____

**Authorization for Release of Information
and
Assignment of Benefits for Medicare**

I request that payment of authorized insurance benefits be made either to me or on my behalf to Associates in General and Vascular Surgery, for any services provided to me by the physician or supplier. I authorize any holder of medical information about me to release to my insurer and its agents any information needed to determine these benefits payable for related services.

I understand that my physician and/or staff will not release any information to my family members or me without verification of my identity in order to comply with privacy regulations. I also understand that information will be released to other healthcare professionals for the coordination of my care/treatment and/or health insurance carriers in the event that it is necessary to process a claim.

By my signature, I state that I have read, understand, and agree to this authorization and release.

Signature

Date

Medigap Authorization

I authorize any holder of medical or other information about me to release information needed for this or a related Medigap claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to either myself or to the party who accepts assignment.

Signature

Date

Policy Number

Associates in General and Vascular Surgery

FINANCIAL POLICY

Please Read Carefully

In non-participating plans, the guarantor is responsible for the difference of usual and customary allowances. In participating plans, the guarantor is responsible for balances as per explanations from the individual's insurance company.

We gladly furnish estimates upon request.

We request that you make payment for all co-payments, deductibles, and office services at the time of your visit. All surgical service balances are expected to be paid within 90 days from the date incurred.

Patients without insurance are asked for a 50% deposit for any elective surgery.

Failure to make payment in full or as stated above or failure to make other financial arrangements for payment will result in your account being placed with a collection agency. You can be charged collection and/or attorney fees which may affect your credit.

We are always available to assist you to collect from your insurance or make payments on your account balance. Your help and cooperation is necessary and appreciated.

I recognize that it is my responsibility to understand my insurance plan and keep AGVS informed of any changes.

Patient/Guarantor Signature

Date

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ACKNOWLEDGEMENT FORM

I understand that, under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information (Our Notice of Privacy Practices). I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly and to obtain payment from third-party payers. I understand that I have the right to review and receive a copy of this Notice before signing this form.

I understand that I may revoke this authorization at any time by submission in writing. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

By signing below, I acknowledge that I have read and understand the terms of this authorization. I hereby knowingly and voluntarily authorize Associates in General and Vascular Surgery to use or disclose my health information in the manner described above.

Please print your name here

Signature

Date

Witness

Associates in General and Vascular Surgery is hereby authorized to discuss my protected healthcare information with the individuals listed below:

Name _____

Name _____

Name _____