TENNESSEE SURGICAL SPECIALISTS, P.C.

NEW PATIENT INFORMATION

DATE_____

Patient's Name (Please Print)	SS #	Marital Status	Gender	Age	Birth Date
Street Address	City & State		Zip	Phone (with Area Code)	
Patient's or Parent's Employer (indicate if Retired)	Occupation (indicate if student)		Daytime Phone (Indicate if Cell, Work, or Home)		
Employer Street Address	City & State		Zip	Work Phone (with Area Code)	
Email Address					

SPOUSE

Name (Please Print)	SS#	Birth Date	
Employer (indicate if Retired)	Employer Street Address	City & State	Zip

EMERGENCY CONTACT

Name (Please Print)	Home Phone:	Other Phone	

ACCIDENT / WORKER'S COMPENSATION / DISABILITY

Date of Accident / Injury	Location of Accident	Type of Accident ☐ Home ☐ Job ☐ Motor Vehicle	Claim #
Case Worker	Phone	Attorney	Phone #
Were X-rays taken?	Where	Describe Any Medical Care Received. Where?	

MEDICAL INFORMATION

Name of Referring Doctor	Phone Number	Name of Family Doctor	Phone Number
Pharmacy Name		Phone Number	

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INSURANCE AUTHORIZATION & ASSIGNMENT

I understand that all professional services are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. I understand that failure to provide the requested information may result in a denial of benefits by insurance carriers. I accept full responsibility for all fees regardless of the insurance coverage. Co-payments are due at the time services are rendered. (Refer to "Acknowledgment of Responsibility of Payment for Services" for additional details)

I request that payment of authorized Medicare/ Medicaid / Insurance Company benefits be made to Tennessee Surgical Specialists on my behalf for any services furnished to me by that physician or physicians associated with that practice. I authorize the release of medical information to the Centers for Medicare & Medicaid Services and its agents or to my insurance carrier and its agents as needed to determine those benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information to pay the claim. My signature below serves as authorization for HCFA-1500 claim form (or its electronic equivalent) blocks 12 and 13. Further more, if item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of information to the insurer or agency shown. In Medicare and other insurance assigned cases (insurance carriers in which Tennessee Surgical Specialists actively participates), the physician agrees to accept the charge determination of Medicare or other insurance company as the full charge, and the patient is only responsible for the co-pay, co-insurance, and deductible as well as any non-covered services. Coinsurance, co-pays, and the deductible are based upon the charge determination of the Medicare or other insurance company.

Name (printed) _____

Patient / Legal Guardian Signature_____ **Date** _____

Relation to Patient (if not signed by patient) _____

TENNESSEE SURGICAL SPECIALISTS, PC

Today's Date:_____

DEMOGRAPHICS

Name: (Last)_____ (First)_____ (Middle)_____

Race: (Circle) African American/African Decent Asian Caucasian Hispanic Indian/Native American

Other:_____

Referring Physician/Primary Care Doctor: _____

Person Filling Out Form: _____

Relationship to Patient: _____

DETAILS OF SYMPTOMS

Describe Symptom(s): _____

_____

Date Symptom(s) Began: _____

Previous Tests: _____

ALLERGIES

Allergies to Medications?: No Yes (List) _____

Latex? No Yes Tape? No Yes Grasses? No Yes Molds? No Yes Pollens? No Yes

LIST ALL CURRENT MEDICATIONS, FREQUENCY, AND DOSAGE
(Or Provide Us With A Current List to Copy)

_____

_____

_____

PAST MEDICAL HISTORY

Abdominal Aortic Aneurysm	Alzheimer's Disease	Anxiety Disorder
Arthritis	Asthma	Bronchitis
Cancer (Type_____)	Cerebrovascular Accident/Stroke	Cholelitiasis/Gallstones
Chronic Lung Disease/COPD	Cirrhosis	Congestive Heart Failure
Deep Venous Thrombosis	Diabetes Mellitus	GERD/Reflux/Heartburn
Gout		
Heart Murmur	Hepatits (A B C)	HIV Positive
Hypercholesterolemia	Hypothyroidism/Low Thyroid	Hypertension/High BP
Hyperlipidemia	Hyperthyroidism/Graves	Irritable Bowel Syndrome
Kidney Failure	Kidney Stones	Migraines
Myocardial Infarction	Non-healing Leg Ulcers	Peptic Ulcer Disease
Rheumatic Fever	Varicose Veins	

Other: _____

☐ **PLEASE CHECK HERE IF YOU HAVE NO SIGNIFICANT PAST MEDICAL HISTORY.**

PAST SURGICAL HISTORY

Abdominal Aortic Aneurysm	Appendectomy	Arthroscopy
Back Surgery	Breast Biopsy	Breast Removal/Mastectomy (Rt Left)
Carotid Endartarectomy	Cesarean Section	Cholecystectomy/Gallbladder Removal
Colon Resection/Removal	Coronary Bypass/Heart	Femoral/Popliteal Artery Bypass
Gastric Bypass		
Heart Catherization	Heart Stent	Hemorrhoidectomy
Hip Replacement	Hysterectomy (Partial Total)	Incisional/Ventral Hernia Repair
Inguinal Hernia Repair (Rt Left)		
Knee Replacement (Rt Left)	Laparoscopy	Nephrectomy/Kidney Removal
Nissen Fundoplication	Lung Biopsy/Lung Removal	Splenectomy
Thyoidectomy	Tonsillectomy	Tonsillectomy & Adenoidectomy
Tubal Ligation	Vasectomy	

Other: _____

☐ **PLEASE CHECK HERE IF YOU HAVE NO SIGNIFICANT PAST SURGICAL HISTORY.**

SOCIAL HISTORY

Marital Status: Single Married Divorced Widow/Widower

Number of Children: _____

Occupation: _____

Living Will: Yes No

Tobacco Use: Never In Past Currently

If yes, select type: Cigarettes Cigars Chew Dip Pipe
How often/How much: _____
When did you start: _____
When did you stop: _____

Alcohol Use: Never In Past Currently

If yes, select type: Beer Liquor Wine
Typical amount: _____
When did you stop: _____

Caffeine Use: Never In Past Currently

How often/How much: _____

Exercise: No Yes

Type of exercise: Aerobics Running Walking Swimming Weights
Other: _____
How many times per week/average: _____

Illicit Drug Use: _____

FAMILY MEDICAL HISTORY

Father: Living Deceased Unknown
If deceased, Age at death: _____
Cause of death: _____

Mother: Living Deceased Unknown
If deceased, Age at death: _____
Cause of death: _____

Number of Siblings: _____
Number of Deceased Siblings: _____
Age(s) at death: _____
Cause(s) of death: _____

List relatives with any of the following:

Blood Clotting Disorder:	Mother	Father	Brother	Sister	Grandparent
Breast Cancer:	Mother	Father	Brother	Sister	Grandparent
Colon Cancer:	Mother	Father	Brother	Sister	Grandparent
Ovarian Cancer:	Mother	Father	Brother	Sister	Grandparent
Diabetes:	Mother	Father	Brother	Sister	Grandparent
Heart Disease:	Mother	Father	Brother	Sister	Grandparent

REVIEW OF SYSTEMS (Please Circle Symptoms)

General:	Change in Appetite	Chills	Decreased Energy Level (Fatigue)
	Fever	Sweats	Change in Weight
Eyes:	Corrective Lenses (Glasses or Contacts)	Cataracts	Discharge
	Dryness	Droopy Eyelids	Eye Pain
	Itchy Eyes	Temporary Loss of Vision	
Ears:	Difficulty Understanding Speech	Drainage	Earache
	Ears Feel Full	Hearing Loss	Frequent Infections
	Sensitivity to Noises	Vertigo (Dizziness)	

REVIEW OF SYSTEMS (CONTINUED)

Nose:	Congestion Itching Sinus Blockage	Discharge Nasal Mass/Lump Snoring	Dryness Nose Bleeds	
Mouth/Throat:	Partial plates/Dentures Difficulty Swallowing Mouth Pain Sore Tongue	Cavities Sore Throat Mouth Sores	Dry Mouth Hoarseness Tongue Burning	
Respiratory:	Coughing Blood	Persistent Cough	Shortness of Breath	Wheezing
Cardiac:	Previous Cardiac Test: _____ Chest Discomfort Cold Hands/Feet Edema Palpitations	Chest Pain Cyanosis Heart Murmur		
Gastro-Intestinal:	Abdominal Pain Constipation Food Intolerance Indigestion Rectal Pain Vomiting	Abdominal Swelling Diarrhea Heartburn Nausea Regurgitation	Change in Stools Excessive Flatulence Hernia Rectal Bleeding Pain When Swallowing	
Reproductive:	<u>Female</u> Genital Sores Pelvic Pain <u>Male</u> Penile Discharge	Genital Pain Post Menopausal Bleeding Sexual Dysfunction	Menstrual Difficulties Sexual Dysfunction	
Urologic:	Abnormal Stream Difficulty/Pain Urinating Change in Urine Volume Incontinence Kidney Stones Recent Infection Stream Interruption	Blood in Urine Change in Urine Feeling of Passing Something in Urine Increased Urine Frequency Need to Urinate More Than Once/Night Urinary Odor Urinary Discharge		
Musculo-Skeletal:	Arthritis Joint Stiffness Tenderness	Backache Joint Swelling Weakness	Joint Pain Muscle Cramps/Pain	
Neurological:	Difficulty Walking Fainting Loss of Balance Paralysis Tingling	Confusion Headaches Loss of Sensation Seizures	Dizziness Lack of Coordination Memory Loss Speech Difficulties	
Skin:	Changes in Hair Change in Skin Texture Dryness Masses/Swelling Redness Ulcerations	Changes in Moles Cracks in Skin Itchy Skin Pain/Tenderness Skin Growth	Changes in Nails Discoloration Jaundice Rash Sores	
Breasts:	Discharge Lumps	Enlargement Skin Change	Inflammation Tenderness	
Psycho-Logical:	Depression Increased Tension Mood Swings	Hostile Feelings Irritability Restlessness	Increased Nervousness Lack of Sleep	
Endocrine:	Change in Body Hair Excessive Thirst/Hunger Temperature Intolerance	Change in Voice Excessive Urination Sudden Skin Redness	Eyes Bulging Increase in Body Odor Unusual Sweating	
Hematologic/Lymphatic:	Previous Blood Transfusions: No Yes Any Reaction: No Yes	Anemia Bruise Easily	Bleed Easily Swollen Nodes	

☐ **PLEASE CHECK HERE IF YOU HAVE NO SIGNIFICANT SYMPTOMS.**