Surgical Group of Gainesville, PA

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REGISTRATION FORM

PATIENT INFORMATION			
Patient's last name	First name	Middle initial	Date of birth
Mailing address City		State	Zip code
Home phone	Work phone	Cell phone	
Social Security number	Today's date	Referring physician	

INSURANCE INFORMATION			
Primary insurance provider	Policy number	Group number	
☐ Check box if same as patient information			
Policy holder's last name	First name	Middle initial	Date of birth
Mailing address	Social Security number	Home phone	
Relationship to policy holder			
☐ Check box if no secondary insurance			
Secondary insurance provider	Policy number	Group number	
Policy holder's last name	First name	Middle initial	Date of birth
Mailing address	Social Security number	Home phone	
Relationship to policy holder			
Preferred Pharmacy	Location	Phone number	

IN CASE OF EMERGENCY			
Emergency contact name	Relationship to patient	Home phone	Work phone

Patient signature _____ Date _____

1143 NW 64th Terrace • Gainesville, FL 32605 • Phone: (352) 331-1201 • Fax: (352) 331-5273

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Patient authorization for Use and Disclosure of Protected Health Information

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By voluntarily signing, I authorize Surgical Group of Gainesville to use and/or disclose certain protected health information (phi) about me to _____

_____

This authorization permits Surgical Group of Gainesville to use and/or disclose the following individually identifiable health information about me:

Medical Records Claims/Billing information Lab results

I do not have to sign this authorization in order to receive treatment from Surgical Group of Gainesville. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Surgical Group of Gainesville
Gainesville, FL
Attn: Medical Records Department.

Signed by: _____

Signature of Patient or Legal Guardian Relationship to Patient

_____

Print Patient's Name Date

_____

Print Name of Patient or Legal Guardian, if applicable

I elect to not allow disclosure of my protected health information to any individual or party that I have not authorized.

_____

Signature of Patient or Legal Guardian Relationship to Patient Date

Surgical Group of Gainesville, PA

LIFETIME AUTHORIZATION

Insurance Assignments and Authorization to Release Information

RELEASE OF INFORMATION I, the below name subscriber, hereby authorize any physician examining and/or treating me to release to any third payer (such as an insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

PHYSICIAN INSURANCE ASSIGNMENT I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

MEDICARE/MEDICAID-Patient's certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for my insurance or third payer within a reasonable period of time not to exceed 30 days.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

Date: _____ Patient: _____

SUBSCRIBER (if different from patient): _____

ORIGINAL SIGNATURE ON FILE AT PHYSICIAN'S OFFICE
MEDIGAP (SECONDARY INSURANCE) SIGNATURE

_____	_____	_____
Name of beneficiary	Health insurance company	Medigap policy number

I request that payment of authorized MEDIGAP benefits be made on my behalf to SURGICAL GROUP OF GAINESVILLE, P.A. for any services furnished me by (physician/supplier). I authorize any holder of medical information about me to release to SURGICAL GROUP OF GAINESVILLE, P.A. any information needed to determine benefits payable for related services

SUBSCRIBER'S SIGNATURE _____ DATE _____

SURGICAL GROUP OF GAINESVILLE, PA

PETER SARANTOS, MD* FACS
BRUCE W. BRIENT, MD* FACS
STANLEY V. DETURRIS, MD* FACS
BRIAN E. PICKENS, MD* FACS
TIMOTHY A. HIPP, MD* FACS
JEFFERY L. ROSE, MD* FACS
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D. ORVIN JENKINS, MD*
GARY A. GROOMS, MD*
ERIC K. THOBURN, MD*
ANTHONY P. MCDONALD, MD*

To All Insured Patients:

Welcome to Surgical Group of Gainesville. We are pleased that you have chosen us to provide your surgical care. We are always striving to provide you and your family with the best surgical and professional service available.

Insurance companies sometimes deny claims because of the lack of information on the patient's part. They will not pay these claims until this information is provided to them by you. if your insurance company has denied our claim because you have not provided the information they may need to process our claim, we may transfer the balance to your responsibility after 30 days of the denial.

For patients who are required to obtain authorization to see us, it will be the patient's responsibility to obtain the authorization. If we do not obtain the authorization, we may transfer the balance to the patient's responsibility. It is our goal to provide you with excellent care, both surgically and professionally. We need your cooperation and appreciate your prompt attention to this matter. Please sign on the space below to verify that this form has been read and is understood.

Thank you,

Insurance Department

Signature: _____ Date: _____

1143 NW 64TH TERRACE • GAINESVILLE, FL 32605 • PHONE: (352) 331-1201 • FAX: (352) 331-5273

Surgical Group of Gainesville, PA

Name: _____

Date of Birth: _____ Age: _____

Why are you here to see the doctor? _____

Primary Care Physician: _____

Referring Physician: _____

Past Medical History

Circle any of the following conditions you have been diagnosed with:

High Blood Pressure	Heart Disease	High Cholesterol	Diabetes
Thyroid Problems	Kidney Problems	Stroke	Liver Disease/Cirrhosis
Hepatitis C	HIV/AIDS	Asthma	Emphysema/COPD
Sleep Apnea	Arthritis	Reflux (Heartburn)	Bleeding Disorder

Have you ever been diagnosed with cancer (circle)? Yes No

If yes, what type? _____

Past Surgical History

List all operations you have had with approximate dates performed

_____

_____

_____

_____

_____

_____

_____

Medications

List all medications that you take including over-the-counter medications and supplements:

_____

_____

_____

_____

_____

_____

_____

_____

Allergies

List all known allergies: _____

_____

Social History

Marital status (circle): Single Separated Married Divorced Widowed

Do you have children (circle)? Yes No If yes, how many? _____

What is your highest level of education? _____

What is your occupation? _____

Do you smoke cigarettes (circle)? Yes No I used to

If yes or if you are a former smoker, how many packs per day? _____

For how many years? _____ For former smokers, when did you quit? _____

Do you drink alcohol (circle)? Yes No Rarely

If yes, how many drinks per day? _____

Family History

Are you adopted? Yes No

Is your father alive? Yes No (if deceased, at what age?) _____

Is your mother alive? Yes No (if deceased, at what age?) _____

Have any of your family member been diagnosed with the following (check all that apply)

	Father	Mother	Brothers	Sisters
Heart Disease	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____
High Cholesterol	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Emphysema/COPD	_____	_____	_____	_____
Bleeding Disorder	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
If so, what type	_____	_____	_____	_____

Has anyone else in your extended family (ie aunts, uncles, or grandparents) been diagnosed with significant medical problems? If so, what type? _____

_____

_____

_____

Has anyone in your immediate family had a problem with anesthesia? If so, please describe.

_____

_____

Review of Systems

(circle all that apply)

General
- Fevers
- Chills
- Weight Loss
- Weight Gain
- Fatigue

Skin
- Rashes
- Itching
- New or Changing Moles

Head
- Headaches

Eyes
- Glasses or Contacts
- Vision Changes
- Double Vision

Ears
- Decreased Hearing
- Ringing in Ears
- Earaches

Nose
- Nosebleeds
- Nasal Drainage

Throat
- Dry Mouth
- Sore Throat

Neck
- Swollen Glands
- Stiffness
- Pain
- Lumps

Breast
- Lumps
- Pain
- Drainage
- Skin Changes

Respiratory
- Shortness of Breath
- Cough
- Wheezing
- Coughing Blood
- Asthma

Cardiac
- Chest Pain
- Irregular Heartbeat
- Palpitations
- Leg Swelling
- Shortness of Breath If Flat

Gastrointestinal
- Abdominal Pain
- Difficulty Swallowing
- Nausea
- Vomiting
- Change in Bowel Habits
- Constipation
- Diarrhea
- Blood in Stools
- Change in Appetite
- Rectal Pain
- Rectal Drainage

Urinary
- Frequency
- Urgency
- Incontinence
- Pain When Urinating
- Blood in Urine

Vascular
- Calf Pain When Walking
- Leg Cramps

Musculoskeletal
- Muscle Pain
- Joint Pain
- Stiffness
- Back Pain

Neurologic
- Dizziness
- Fainting
- Seizures
- Weakness
- Loss of Consciousness
- Numbness
- Tingling
- Tremor
- Speech Problems

Hematologic
- Easy Bruising
- Easy Bleeding
- Blood Clots

Endocrine
- Heat Intolerance
- Cold Intolerance
- Sweating
- Excessive Thirst

Psychiatric
- Memory Loss
- Depression
- Anxiety