Surgery Clinic of Milan

Dr. Kenneth H. Tozer, MD - Beth Long, FNP – Dr. Misty Allen MD (Primary Care)

Patient first name: ______________________ Middle initial: ______ Last name: ________________________

Date of Birth: ____/______/______ SSN: _____/_____/______ Sex: Male/ Female

Mailing Address: ____

City: __________________ State: ______________Zip Code: ________________

Home Phone number:____

Cell Phone number: ____

Emergency contact name and phone number: ____

Email Address: ____

Primary Care Physician: ____

Pharmacy and City: ____

(all prescriptions will be sent to the pharmacy listed unless you specify otherwise)

Are you currently living at a skilled nursing facility, nursing home or rehab facility? If so, please list the name, phone number and address of the facility:

____

Primary Insurance: ____

Policy Holder's Name: ______________________________ Relationship to Patient: _____________________

Secondary Insurance: ____

Policy Holder's Name: ______________________________ Relationship to Patient: _____________________

I do not have insurance and will be a self-pay patient ________

MEDICAL HISTORY

Personal History: (please circle all that apply)

High blood pressure
Thyroid Disease______
Diabetes
Arthritis
Hepatitis -type______
HIV
Asthma
COPD
Osteoporosis
Cancer/type________________________________

GOUT
Enlarged Prostate
Kidney Disease ___________
Autoimmune Disorder __________
Stroke
Epilepsy/Seizures
Sleep Apnea
Anemia
Depression

Anxiety
High Cholesterol
Cirrhosis of Liver
Heart Disease ____________
Congestive Heart Failure
Irregular Heartbeat

Other:____

Surgical History: (please circle all that apply)

Appendectomy
Knee Replacement
Cholecystectomy (gallbladder)
Prostate Surgery
Hysterectomy
Thyroidectomy _________
Tubal Ligation
Back surgery
Neck surgery
Hip Replacement _____
Tonsillectomy

Hemorrhoidectomy
Hernia Repair type: _____________
Vasectomy
Cesarean Section
Carpal Tunnel Release
Breast Augmentation/Reduction
Breast Biopsy __________
Mastectomy:____________
Cardiac Stents year: __________
Pacemaker year: ____________
Cardiac Bypass year:___________

Kidney Stones

Other:____
____

Do you have a **family history** of the following:

Unknown/Adopted
Heart Disease: Y/N Diabetes: Y/N Hypertension: Y/N
Do you have a family history of BREAST or COLON cancer? If so, which family member? __________________

Social History

Do you smoke? Y/N Do you drink alcohol? Y/N Do you use illegal drugs? Y/N

Patient Name:____

Current Medications

Allergies:____

____

Are you on any blood thinners? Y/N

Name of blood thinner: ____________________ Dosage:____________

Name of blood thinner:____________________ Dosage:____________

Reason for blood thinner:______________________________

Other Medications:

Please list name of medication, dosage, and how many times per day/week

Medication: ____________________ Dosage: ____________

Medication: ____________________ Dosage: ____________

Medication: ____________________ Dosage: ____________

Medication: ____________________ Dosage: ____________

Medication: ____________________ Dosage: ____________

Medication: ____________________ Dosage: ____________

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Medication: ____________________ Dosage: ____________

Medication: ____________________ Dosage: ____________

SURGERY CLINIC OF MILAN

Notice of Privacy Practices:

We keep a record of the health care services we provide you. We will not disclose your records to anyone other than privileged individuals such as referring physicians and insurance companies without your permission or unless the law authorizes or compels us to do so.

Signature: ______________________________ **Date:** ____________

Authorization to Share Healthcare Information:

(This could include family members, friend, children, etc. This does not pertain to other physicians) I permit you to share my medical information, appointments, etc. with the following:

Name: ______________________________ **Relationship:** ____________

Name: ______________________________ **Relationship:** ____________

Consent for Treatment and Release of Information:

I understand that information obtained by this authorization will be used to determine eligibility for insurance and eligibility for benefits under my coverage. Any information will not be released except to persons or organizations performing business or legal services in connection with the claim, or as may be otherwise lawfully required or as I may further authorize. I agree authorization shall be valid until rescinded in writing or replaced by one of later date.

Signature: ______________________________ **Date:** ____________

Financial Policy:

It is essential that you understand what services are covered under your insurance plan. Your doctor may recommend services that he/she feels are beneficial but may not be covered under your insurance plan. It is your responsibility to understand the limits pertaining to your insurance coverage. Patients who do not have insurance are expected to pay in full at the time of service. If you can not pay the full amount, then you must make arrangements with our office prior to your receiving services. I understand that I am financially responsible to Surgery Clinic of Milan for charges not covered by my insurance plan. I understand that if my bill is not paid in a timely manner, I will be subject to a penalty if sent to an outside collection office.

Signature: ______________________________ **Date:** ____________

Insurance Billing Information:

I authorize treatment and agree to pay all fees associated with such treatment. I authorize my insurance benefits to be paid directly to my physician. I authorize my physician to release any information required to obtain reimbursement. I agree that I am financially responsible for all services provided and should it be necessary to refer the account to a collection agency, I will be responsible for all fees including but not limited to collection costs, fees and court costs involving my account.

Signature: ______________________________ **Date:** ____________