The Su Surgical Group

Name: _____ **Date of Birth:**_____

Address: _____

City, St., Zip: _____

SSN: _____ **Primary Doctor:**_____

Race (please circle one): White Hispanic African American Asian Other Decline to answer

Primary Language: English Other: _____

Referring Doctor:_____

Contact Information: This sections refers to the methods we will contact you or your authorized contact person.

Please circle your preferred method of contact for appointment reminders:
Home phone Mobile Text (your messaging rates will apply) Email

Home Phone: _____ **Cell Phone**:_____

Work Phone:_____ **E-mail address**:_____

Pharmacy: _____ **Location:** _____

Please list who we are allowed to contact in case of emergency or to discuss healthcare matters such as test results and scheduling:
Name:_____ Phone: _____Relationship:_____

Name:_____ Phone: _____Relationship:_____

Insurance and Payment Information

Primary Insurance:_____ Policy#:_____ Group#_____

Policy Holder:_____ DOB:_____ SSN:_____

Secondary Insurance:_____ Policy#:_____ Group#_____

Policy Holder:_____ DOB:_____ SSN:_____

The Su Surgical Group

Please check here if this is a worker's compensation claim: ____

Please check here if you are a self-pay: _____

If you have checked either of the two conditions above, please contact our office prior to your appt.

Name of person financially responsible if other than patient:_____

Financial information, authorization for treatment, and privacy notification

Financial Responsibility: I certify that the information provided above regarding my demographics and insurance coverage is correct. I agree to pay any copayment, coinsurances, or deductible as required by my insurance plan for medical care provided to me or my dependent. I understand that co-payments, co-insurance, deductibles and account balances will be collected at the time of service. If surgery is scheduled, a portion of the deductible may be required before surgery.

Collection Agency Fees: If my account becomes assigned to a collection agency, I agree to pay all collection agency fees, court costs, and attorney fees. I understand that non-payment of my account may result in a discharge from the practice with 30 days notice.

Pharmacy Benefit Management: By signing below, I give consent for William T. Su, MD PA to download medication history for me. This will share any medications paid for by my insurance company into our medical record. Please initial here: _____

Authorization for Medical Billing: I hereby authorize William T. Su, MD PA to submit a claim, and if necessary a copy of my related medical records to my insurance plans for purposes of receiving payment for medical services provided to me or my dependent. I authorize William T. Su, MD PA to verify insurance coverage and benefits allowed in accordance with my insurance plan's policies. I authorize the payments be made directly to William T. Su, MD PA for all medical insurance benefits which are payable under the terms of my insurance for services provided.

Receipt of Privacy Notice: By signing below I acknowledge that I have the opportunity to review William T. Su, MD PA's Notice of Privacy Practices which provides a detailed description of how my Protected Health Information is used or disclosed. It is available for review at the front desk upon request.

Signature of Patient and/or Guardian (SEAL):_____

Date: _____

SELF HISTORY SHEET

Name: _____ **DOB:** _____

Signature:_____ **Date:**_____

Signature indicates that all information given on this sheet is true to the best of my knowledge.

Preferred Pharmacy_____ **Location**:_____

Referring Physician: _____ **Primary Physician:**_____

Reason for your visit:

_____

_____

Past Medical History: Place a Y or N if you have ever had any of the following illnesses:

Arthritis:	_____	High Blood Pressure:	_____	Thyroid Disease:	_____
Asthma:	_____	Heart Disease/A-Fib:	_____	Varicose Veins:	_____
Diabetes:	_____	Renal Failure:	_____	Emphysema/COPD:	_____
Cancer:	_____	Peptic Ulcer:	_____	Stroke:	_____
Specify Type of Cancer:_____				High Cholesterol:	_____

Other Illness not listed above:_____

Past Surgical History: Check here if none [ ]

Date	Procedure	Hospital	Doctor

Medications: (Please list any medications you take, check here if none [ ])

**If you have a separate list, please attach we can return your copy when you come in.

Check here if you are giving us a separate list [ ]

Name of Medication	Dose	How Often do you take it?

Allergies: Check here if you have no known allergies to drugs: ☐

Allergy to Meds: _____

_____

Latex: _____ If yes, what reaction?_____

Seafood: _____ If yes, what reaction?_____

Contrast Dye: _____ If yes, what reaction?_____

Family History: (Circle if any of your immediate family members have had the following illnesses)

Aneurysm:	Dad__Mom__Sis__Bro__	Heart Disease:	Dad__Mom__Sis__Bro__
Anemia/bleeding:	Dad__Mom__Sis__Bro__	High Blood Pressure:	Dad__Mom__Sis__Bro__
Stroke:	Dad__Mom__Sis__Bro__	Kidney Disease:	Dad__Mom__Sis__Bro__
Carotid Disease:	Dad__Mom__Sis__Bro__	Diverticular/Crohn's:	Dad__Mom__Sis__Bro__
Cancer:	Dad__Mom__Sis__Bro__	Diabetes:	Dad__Mom__Sis__Bro__
Specify type of cancer: _____		Malignant Hyperthermia:	Dad__Mom__Sis__Bro__

Other Health issues that family members have had that we should know about:_____

_____

Social History:

Smoking status: Current smoker ____ Former smoker _____ Never _____

Do you use any other tobacco products?_____ If yes, what kind & how often?_____

Do you drink alcohol? _____ If yes, how many drinks per day?_____

Please circle one: Retired / Disabled / Self- Employed / Homemaker / Employed

What type of work do you do? _____

Marital Status: Single_____ Married_____ Divorced _____ Widowed _____

Review of Systems: (Answer all questions with Yes if you CURRENTLY have these symptoms)

Integumentary (skin)

Rashes: _____ Boils/infection: _____ Hair loss: _____

Eye, Ear, Nose, & Throat

Change in Vison: _____ If yes, describe:_____

Change in Hearing: _____ If yes, describe:_____

Difficulty swallowing: _____ Hoarseness : _____

Cardiovascular

Chest Pain/angina:_____ Irregular Heart beat?_____ Leg Ulcers:_____

Leg swelling:_____ Pain In legs after walking?_____ Leg discoloration: _____

Respiratory

Shortness of breath: _____ Wheezing:_____ Chronic chough:_____

Gasto-Intestinal

Pain in abdomen_____ Describe:_____

Changes in appetite:_____ If yes, describe:_____

Weight gain _____ Weight loss_____ Heartburn _____

Vomitting:_____ Blood in vomit?_____ Nausea _____

Diarrhea:_____ Constipation:_____ Bleeding with bowel movements:_____

Pain with bowel movements:_____ Black bowel movements:_____

Genito-Urinary

Blood in urine: _____ Burning or pain when urinating:_____

History of kidney stones: _____ Chronic urinary infection: _____

Women

Number of children:_____ Any miscarriages:_____ Date of last period:_____

Contraceptive use:_____ If yes, state what kind:_____

If you do not menstruate, when did you stop?_____

Musculo-Skeletal

Back pain:_____ Joint pain:_____ Stiffness:_____ Leg pain/cramping:_____

Nervous System

Headache:_____ Fainting:_____ Seizures:_____ Dizziness:_____

Memory loss:_____ Numbness:_____ Weakness:_____ Paralysis:_____

Difficulty sleeping:_____

Heme-Lymph

Easy bleeding: _____ Easy bruising: _____ Discoloration of skin: _____

Lymph node enlargement: _____