Advanced Surgical Associates

NAME: _____ **DATE OF BIRTH:** _____

Have you ever had or are suffering from any of the following:

	YES	NO
Arthritis		
Blood Clots		
Cancer or Tumors		
Diabetes		
Heartburn		
Heart Disease		
Hepatitis		
High Blood Pressure		
Hemorrhoids		
Gallbladder Trouble		
Kidney/Bladder Problems		
Liver Disease		
Lung Disease		
Stroke		
Ulcers		
Vascular Disease		
Weight Loss/Gain		

MEDICATIONS CURRENTLY TAKING:

Type:	Prescription:
☐ Blood Thinner	_____
☐ Diabetes	_____
☐ Birth Control	_____
☐ Diuretic *(water pill)*	_____
☐ Blood Pressure	_____
☐ Ulcer	_____
☐ Antibiotic	_____
☐ Arthritis	_____
☐ Nerves	_____
☐ Other	_____
☐ Other	_____

FAMILY MEDICAL HISTORY (Check this box if any of the following apply to your relatives).

	Father	Mother	Brother	Sister	Grandmother	Grandfather
Arthritis	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Vascular Disease	☐	☐	☐	☐	☐	☐

Other: _____

SURGICAL HISTORY (List most recent and approximate year): _____

_____

ALLERGIES (List all medications that you are allergic to): _____

_____

Your signature tells us that you have answered the above questions to the best of your knowledge. All answers are considered privileged medical information and are kept confidential.

Signature: _____ Date: _____

Parent and/or Legal Guardian

1722 Pine Street, Suite 904 • Montgomery, Alabama 36106 • P:334-265-9225 • F: 334-265-9257

PATIENT INFORMATION
(Please Print)

INSURANCE INFORMATION

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____

CITY: _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

SEX ☐ F ☐ M MARITAL STATUS ☐ Single ☐ Married ☐ Widowed ☐ Divorced

SS# _____ D.O.B. _____ Age: _____

PRIMARY MEDICAL PHYSICIAN _____

REFERRING PHYSICIAN _____

REASON FOR SEEING THE DOCTOR TODAY _____

PRIMARY INSURANCE NAME _____

Policy# _____ Group # _____

NAME OF POLICY HOLDER _____

POLICY HOLDER'S DATE OF BIRTH ____ / ____ / ____

SECONDARY INSURANCE NAME _____

Policy# _____ Group # _____

NAME OF POLICY HOLDER _____

POLICY HOLDER'S DATE OF BIRTH ____ / ____ / ____

EMERGENCY CONTACT
(Friend or Relative)

NAME _____ RELATION _____

HOME PHONE _____ CELL PHONE _____

I authorize the release of any medical information necessary to process claims. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance company.

I agree to pay all copayments and deductibles at the time the service is rendered.

_____ _____

Signature of Patient or Guardian Date