Wiregrass SURGICAL

Flowers Hospital Doctor's Center
4300 West Main St., Ste. 24, Dothan, AL 36305
Office. 334.793.1534 | *Toll-Free.* 800.464.7951 | *Fax.* 334.793.6840
www.wiregrasssurgical.com

WIREGRASS SURGICAL PATIENT INFORMATION FORM

PATIENT'S FULL NAME: _____PREFERRED NAME: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE: _____DOB: _____

HOME PHONE: _____CELL PHONE: _____

EMPLOYER: _____WORK PHONE: _____

E-MAIL:_____

SOCIAL SECURITY #: _____ DRIVERS LICENSE #: _____

PREFERRED PHARMACY: _____ PHARMACY ZIPCODE#: _____

SEX ( ) Male ( ) Female MARITAL STATUS ( ) Single ( ) Married ( ) Divorced ( ) Widow

RACE ( ) American Indian/Alaskan Native ( ) Asian ( ) Black/African American ( ) Pacific Islander ( ) White Other: _____

REFERRING PHYSICIAN: _____FAMILY PHYSICIAN: _____

Primary Insurance: _____ Policy Holder: _____
Member ID/Policy #: _____Group #: _____
Date-of-Birth: _____

Secondary Insurance: _____ Policy Holder: _____
Member ID/Policy #: _____Group #: _____
Date-of-Birth: _____

Tertiary Insurance: _____ Policy Holder: _____
Member ID/Policy #: _____Group #: _____
Date-of-Birth: _____

EMERGENCY CONTACT AND PERSON(S) WE MAY RELEASE INFORMATION TO:

NAME: _____RELATION: _____ PHONE: _____

NAME: _____RELATION: _____ PHONE: _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize Wiregrass Surgical Associates, P.C. to release all medical records and pertinent medical information to any insurer, governmental agencies providing benefits, or to anyone liable for charges. I also authorize release of said information to my referring physician and to other medical providers who are or may become involved in my treatment.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I may obtain a copy of the Notice of Privacy Practices. Upon arrival, copies will be made available at my request. I also acknowledge that a copy is posted in the patient waiting area and available to access for my personal review.

SIGNATURE: _____ DATE: _____

PLEASE DO NOT SIGN BELOW: OFFICE USE ONLY

Verify: ____ ____ ____
Date: _____ _____ _____

Chart number:_____ Date: _____

Medical Questionnaire

Patient Name :_____ Date of Birth:_____

Who is your Primary Care Physician? _____

Are you under a pain management agreement? ❒ Y ❒ N If Yes, who is your physician? _____

Do you have a cardiologist (heart doctor)? ❒ Y ❒ N If Yes, who is your physician? _____

Is this visit related to a Worker's Compensation claim? ❒ Y ❒ N If yes, date of injury: _____

Reason for Visit

What is the reason for your visit today? _____

How long have you had this problem? _____ Have you had this problem before? ❒ Y ❒ N

On a scale of 0 – 10 (10 is the worst), how severe is your pain? ❒0 ❒1 ❒2 ❒3 ❒4 ❒5 ❒6 ❒7 ❒8 ❒9 ❒10

What is the quality of your pain? ❒ Sharp ❒ Dull ❒ Stabbing ❒ Throbbing ❒ Aching ❒ Burning

The pain is ❒ Constant ❒ Comes and goes

Tests/Scans – Have you had any tests or scans for this problem?

❒ X-rays ❒ MRI ❒ CAT scan ❒ HIDA scan ❒ Ultrasound ❒ Mammogram/breast imaging

❒ Other: _____

Facility where tests/scans were performed: _____

Medication Allergies

Are you **allergic** to any medications? ❒ Yes ❒ No If yes, please list and describe reaction:

Medication	Reaction

Chart number:_____ Date: _____

What medications do you take on a daily basis? Include over-the-counter, prescriptions and vitamins.

Name	Dose	Frequency (How often)

Chart number:_____ Date: _____

Family History – Indicate **M** for Mother; **F** for Father; **S** for Sister, **B** for Brother

❒ No current problems/disabilities _____
❒ Aneurysm _____
❒ Blood clotting disorder _____
❒ Breast cancer _____
❒ Colon cancer _____
❒ Diabetes mellitus _____
❒ Heart disease _____
❒ Hypertension _____
❒ Hyperthyroidism _____
❒ Hypothyroidism _____
❒ Stroke _____

Social History

Marital Status: ❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Live alone ❒ Live with others
Occupation: _____ ❒ Student ❒ Retired
Do you drink alcohol? ❒ Yes ❒ No ❒ Occasionally/Socially
Smoking status: ❒ Never smoked ❒ Former smoker ❒ Current smoker
Chewing Tobacco: How much? _____
Vape/Vapor: ❒ Yes ❒ No

Surgical History – Please check **ALL** that apply:

❒ Adenoidectomy
❒ Aneurysm Repair
❒ Appendectomy
❒ Breast Augmentation
❒ Breast lump (right or left)
❒ Breast lumpectomy for cancer (right or left)
❒ Bowel resection
❒ Bladder surgery
❒ Back surgery
❒ Colonoscopy
❒ Colectomy
❒ Cesarean Section
❒ Coronary Artery Bypass Graft (CABG)
❒ Diagnostic Laparoscopy
❒ Defibrillator
❒ EGD
❒ Exploratory Laparotomy
❒ Gastric Sleeve
❒ Gastric Bypass
❒ Gallbladder (laparoscopic or open)
❒ Hernia repair with mesh (specify: _____)
❒ Hernia repair without mesh (specify: _____)
❒ Hiatal Hernia Repair
❒ Hysterectomy (partial or complete)
❒ Heart catheterization
❒ Heart stent
❒ Heart valve
❒ Hemorrhoidectomy
❒ Incision and Drainage of Abscess
❒ Joint Replacement (specify: _____)
❒ Joint Surgery (specify: _____)
❒ Lap Band
❒ Lung Surgery
❒ Mastectomy (left or right)
❒ Nephrectomy
❒ Nissen Fundoplication
❒ Pacemaker
❒ Prostate Surgery
❒ Powerport/Infusaport
❒ Tubal ligation
❒ Thyroidectomy (circle one: left right total)
❒ Tonsillectomy
❒ Wide Local Excision for Skin Cancer

Other:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Chart number:_____ Date: _____

Past Medical History – Please check **ALL** that apply:

- ❒ AIDS/HIV
- ❒ Acid Reflux (GERD)
- ❒ Adrenal Disease
- ❒ Anemia
- ❒ Anesthesia Complications
- ❒ Aneurysm
- ❒ Anxiety/Depression
- ❒ Arthritis
- ❒ Artificial Joints
- ❒ Asthma
- ❒ Atrial Fibrillation
- ❒ Bleeding Disorder
- ❒ Blood Clot
- ❒ Brain Injury
- ❒ COPD
- ❒ Cancer (Type: _____)
- ❒ Cerebral Palsy
- ❒ Chemotherapy
- ❒ Cirrhosis
- ❒ Congestive Heart Failure (CHF)
- ❒ Dementia
- ❒ Diabetes
- ❒ Dialysis
- ❒ Depression
- ❒ Enlarged heart
- ❒ Epilepsy/Seizures
- ❒ Enlarged Heart
- ❒ Gastric ulcers
- ❒ Gout
- ❒ Heart attack (MI)
- ❒ Heart Disease
- ❒ Heart Attack (MI)
- ❒ Heart Failure
- ❒ Heart Valve Disease
- ❒ Heart Rhythm Changes
- ❒ Hepatitis
- ❒ Hernia
- ❒ Home Oxygen
- ❒ Hypertension
- ❒ Kidney Disease
- ❒ Kidney Stones
- ❒ Leg or Foot Ulcers
- ❒ Lupus
- ❒ Lyme Disease
- ❒ MRSA infection
- ❒ Neuropathy
- ❒ Obstructive Sleep Apnea
- ❒ Peripheral Vascular Disease
- ❒ Pulmonary Embolism
- ❒ Pregnant
- ❒ Radiation Treatment
- ❒ Sickle Cell Disease
- ❒ Multiple Sclerosis
- ❒ Tuberculosis
- ❒ Hypothyroidism
- ❒ Hyperthyroidism
- ❒ Other:

_____
_____
_____
_____
_____
_____
_____
_____
_____

The information provided on this Medical Questionnaire is accurate to the best of my knowledge.

_____ _____

Signature Date

Wiregrass Surgical Risk Assessment Form for Hereditary Cancer Screening Program

Please complete this form **accurately and to the best of your ability. We will review it with you upon arrival.*

Patient Name: _____ Insurance: _____

Date of Birth: _____ Physician: _____ Today's Date: _____

This is a <u>screening tool for cancer</u> that runs in families. Please consider the following family members when completing the form:

1st Degree Relatives = Mother/Father/Sister/Brother/Children

2nd Degree Relatives = Aunt/Uncle/Grandparent/Grandchild/Niece/Nephew

3rd Degree Relatives = Cousin/Great-Grandparent/Great-Aunt/Great-Uncle

Have YOU or ANY OF YOUR RELATIVES been tested (BRCA/Colaris) for a Hereditary Cancer Syndrome? YES NO

Have YOU ever been diagnosed with ANY type cancer? YES NO If so, what Site: If so, what age:

		BREAST & OVARIAN CANCER (HBOC/BRAC*Analysis*)	Self	Siblings or Children	Your Relationship to Family Member		Age at Diagnosis	Living?
					Mother's Side	Father's Side		
Y	N	Breast Cancer at Age 45 or Younger (in Self, 1st or 2nd Degree Relative)						☐
Y	N	Ovarian Cancer at Any Age (in Self, 1st, 2nd or 3rd Degree Relative)						☐
Y	N	**2 Relatives** on Same Side of Family with Breast Cancer - **1 of them under the Age of 50**						☐
Y	N	3 Relatives on Same Side of Family with Breast Cancer at Any Age						☐
Y	N	**Multiple** Breast Cancers in the Same Person (in the same breast OR both breasts)						☐
Y	N	Triple Negative Breast Cancer (ER, PR and Her2 Negative Receptor Status) at Age 60 or Younger						☐
Y	N	Male Breast Cancer at Any Age (in Self, 1st, 2nd or 3rd Degree Relative)						☐
Y	N	Pancreatic Cancer with Breast, Ovarian or Prostate Cancer in the same person or on same side of the family						☐
Y	N	**Ashkenazi Jewish** ancestry with Breast, Ovarian or Pancreatic Cancer in same person or on same side of family						☐
Y	N	Family member with a known BRCA mutation						☐
		COLON & UTERINE CANCER (Lynch Syndrome/Colaris)	**Self**	**Siblings or Children**	**Your Relationship to Family Member**		**Age at Diagnosis**	**Living?**
					Mother's Side	**Father's Side**		
Y	N	Colon (Colorectal) or Uterine (Endometrial) Cancer before Age 50 (in Self, 1st or 2nd Degree Relative)						☐
Y	N	**2 or more** Relatives on Same Side of Family with any of the following - **(circle): *Colon, Uterine/Endometrial*** *, Ovarian, Stomach, Small Bowel, Brain, Kidney/Urinary Tract, Ureter, Renal Pelvis, Pancreas*						☐
Y	N	**3 or more** Relatives on Same Side of Family with any of the following (circle): ***Colon, Uterine/Endometrial*** *, Ovarian, Stomach, Small Bowel, Brain, Kidney/Urinary Tract, Ureter, Renal Pelvis, Pancreas*						☐
Y	N	Family member with a known Lynch Syndrome mutation						☐

Patient Signature: _____ HCP Signature: _____

For Office Use Only:

☐ Based on Personal & Family History, testing is NOT indicated for the Patient at this time. Chart #: _____

☐ Genetic Testing Recommended for Patient: BRACAnalysis (HBOC) or Colaris (Lynch)

☐ Patient Declined & Reason: _____

☐ Patient Accepted

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WIREGRASS SURGICAL FINANCIAL POLICY FORM

Thank you for selecting our office for your medical care. In order to prevent any misunderstandings concerning the responsibility for payment of medical and surgical services provided to our patients, the following is supplied: ***Please understand that our service agreement is with YOU and NOT your insurance company.*** *You are responsible for payment for the service(s) rendered not covered by your chosen insurance company.*

ASSIGNMENT OF BENEFITS

For services received, I hereby authorize and direct that payment(s) be made directly to **Wiregrass Surgical Associates, P.C.** for benefits payable under the terms of my policy. I recognize that if payment is made directly to me, the amount received, up to the amount due for services rendered, is the property of **WSA** and should be paid over to **WSA** immediately. I understand that I am financially responsible for charges not paid by this assignment.

MEDICARE

We are participating providers of Medicare Part B only. **Please remember that if you only have Medicare, the remaining 20% of the allowable fee plus the Medicare deductible (if not already met) is the patient's responsibility.**

MEDICAID

We are participating providers of Medicaid. If you are a Medicaid recipient, please provide us with your card to verify eligibility and your co-pay at the time of service, if applicable. If you have Medicaid coverage pending, we require payment for the services at the time of your visit. If it becomes retroactive and Medicaid pays for the services, we will refund your payments in coordination to what Medicaid has covered.

OTHER INSURANCES

Co-payments for office visits are required at the time of arrival. After filing with your insurance, if a balance is put to your responsibility, prompt payment is required. Deductibles and co-insurance are due prior to surgery. Our Financial Director is here to help explain your financial responsibility. For your convenience, we are pleased to accept various forms of payment as well as offer financial lending assistance.

REFERRALS

It is your responsibility to bring any required referrals for treatment at or prior to the visit. **If you do not have the referral, you may be asked to reschedule your appointment until one is acquired.**

RETURNED CHECKS AND DELIQUENT ACCOUNTS

There will be a **$25.00** charge for all returned checks. If your account becomes delinquent and must be placed with a collection agency, you agree to accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such is necessary.

PRIOR CONSENT TO CONTACT BY CELL PHONE

You agree, in order for us to service your account or collect monies you may owe, we may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages and/or emails. Methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

PERSONAL FORMS

There will be a fee of $25 **per form** that must be paid prior to our office completing (ex: disability, FMLA, personal policy claims, etc.). We also ask that you give us 5 business days following the date of the procedure to complete these form. Most forms cannot be completed until after surgery is performed and our physician has completed all associated notes.

*I have read and understand this policy and my financial responsibilities to Wiregrass Surgical Associates, P.C.

Patient's Signature: _____ DOB: _____
Patient's Social Security Number: _____ Date: _____
If Minor - Adult's Acknowledgement: _____ Date: _____
If Minor - Adult's Social Security Number: _____-_____-_____

WS EMPLOYEE WITNESS _____

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The surgeons at Wiregrass Surgical often times utilize the assistance of a physician assistant or nurse practitioner during surgery and for office clinics, as well as sometimes require the use of another physician to assist in surgery cases. The assistance of these individuals, who have been specialty trained, ensures that your surgery goes smoothly and safely, and is best for quality patient care.

Please be advised that while many insurance companies cover the costs associated with this, if our group is considered out of network with your provider, or if you are receiving care that is not considered a covered service with your insurance provider, then you may be responsible for these charges. Please also be aware that allowable charges will be processed with your insurance provider for those who assisted in your care in addition to your primary surgeon, so you may see those providers listed on any claims, benefit or insurance statements. For your reference, all of our providers are listed below.

If you have questions regarding this information, please ask to speak with someone in our insurance department.

Thank you,

The Physicians of Wiregrass Surgical

Patient Signature:_____ Date:_____

<u>Wiregrass Surgical Providers</u>
Steven M. Fendley, MD
R. Burton Pfeiffer, MD
Bradley T. Marker, MD
Emily E. Cannon, MD
J. David Roy, MD
Kyle M. Bess, MD
Leigh Phillips, CRNP
Sarah Beth Sloop, PA
Sara Krystyn, CRNP