Lubbock Surgical Associates, LLP

Ted Allen, MD, FACS   Derick Haggard, MD, FACS   David Mangold, MD, FACS
Sammy Rivas, MD, FACS   Richard Rosen, MD, FACS   Travis D Eggl, DO

DATE: **ACCT:**

PATIENT: LAST NAME	FIRST NAME	MIDDLE NAME

MAILING ADDRESS	CITY, STATE	ZIP

SEX	BIRTHDATE	SOCIAL SECURITY NUMBER	AGE	HOME TELEPHONE

EMPLOYER/SCHOOL NAME	WORK TELEPHONE	CELL TELEPHONE

EMPLOYER/SCHOOL ADDRESS	CITY, STATE	ZIP

EMAIL ADDRESS

SPOUSE EMPLOYMENT INFORMATION

SPOUSE LAST NAME	FIRST NAME	MIDDLE NAME

EMPLOYER	WORK TELEPHONE

EMPLOYER ADDRESS	CITY, STATE	ZIP

PATIENTS STATUS: A) ☐ SINGLE ☐ MARRIED ☐ OTHER
B) ☐ EMPLOYED ☐ FULL TIME STUDENT ☐ PART TIME STUDENT

PRIMARY CARE PHYSICIAN:	TELEPHONE #:

PATIENTS RELATIONSHIP TO INSURED : ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

MEDICARE NUMBER	MEDICAID NUMBER

PRIVATE OR GROUP INSURANCE

ARE YOU A MEMBER OF A MANAGED CARE PLAN? (PPO,HMO,ECT?) ☐ YES ☐ NO

NAME OF PRIMARY (FIRST) INSURANCE COMPANY

POLICY NUMBER	GROUP NUMBER	GROUP NAME

POLICY HOLDERS LAST NAME	FIRST NAME	MIDDLE NAME

SEX	BIRTHDATE	SOCIAL SECURITY NUMBER	AGE	HOME TELEPHONE

MEDICARE SUPPLEMENTAL OR ADDITIONAL INSURANCE COMPANY

NAME OF SUPPLEMENTAL OR SECONDARY INSURANCE COMPANY

POLICY NUMBER	GROUP NUMBER	GROUP NAME

POLICY HOLDERS LAST NAME	FIRST NAME	MIDDLE NAME

SEX	BIRTHDATE	SOCIAL SECURITY NUMBER	AGE	HOME TELEPHONE

PERSON TO CALL IN EMERGENCY: RELATIONSHIP:	TELEPHONE:

Signature: ____________________________________

Lubbock Surgical Associates, LLP

Patient History/Medications

Date: ______________________ **Account #:** ______________________

Patient: ______________________ **Age:** ______

Patient Medical History:	Yes	No		Yes	No
Diabetes	☐	☐	Arthritis/gout	☐	☐
(if yes: Diet /pills/Insulin)			Convulsions	☐	☐
Hypertension	☐	☐	Bleeding tendency	☐	☐
Cancer	☐	☐	Acute infections	☐	☐
(if yes: what organ(s):			Venereal disease	☐	☐
Stroke	☐	☐	Hereditary defects	☐	☐
Heart trouble	☐	☐	Lung Disease	☐	☐
(if yes arrhythmia, heart failure, bypass)					

MEDICATIONS- (Including: Prescription, Herbal, Diet, Blood Thinners, (ASA, Plavix, Coumadin) or Over the Counter (Vitamin E, Fish Oil))

MEDICATIONS/DRUG ALLERGY	**REACTION (wheezing, shortness of breath, rash)**

Review of Systems

Lubbock Surgical Associates, LLP

Name: **Date:** **Account:**

Chief Complaint:

Signs/Symptoms:

Referring Physician: **Telephone:**

1. GENERAL:	Yes	No
Chills	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Rash	☐	☐
Weight loss	☐	☐

2. CARDIOVASCULAR:	Yes	No
Chest pain w/ exertion	☐	☐
Defibrillator	☐	☐
Mitral valve prolapse (MVP)	☐	☐
Pacemaker	☐	☐
Phlebitis/blood clots (leg)	☐	☐
Rapid & irregular heartbeats	☐	☐
Rheumatic Fever	☐	☐
Shortness of breath w/ exertion	☐	☐
Swelling in legs and/or feet	☐	☐
Heart Attack	☐	☐
Angina	☐	☐
High Blood Pressure	☐	☐
Varicose Vein(s)	☐	☐
Leg pain w/ walking	☐	☐

3. ENDOCRINE:	Yes	No
Excessive thirst	☐	☐
Excessive urination	☐	☐
Thyroid Disease	☐	☐

4. EYES, EAR, NOSE, THROAT:	Yes	No
Blurred or Double vision	☐	☐
Glasses/Contacts	☐	☐
Glaucoma	☐	☐
Headache	☐	☐
Hearing loss	☐	☐
Ringing	☐	☐
Sinus problems	☐	☐
Swallowing difficulty	☐	☐
Vertigo/Dizziness	☐	☐

5. GASTROINTESTINAL:	Yes	No
Abdominal pain	☐	☐
Blood in stool	☐	☐
Change in stool (size/narrow)	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Heartburn/ Indigestion	☐	☐
Jaundice	☐	☐
Light (white) Stools	☐	☐
Nausea	☐	☐
Rectal Bleeding	☐	☐
Rectal pain	☐	☐
Reflux/ Indigestion	☐	☐
Tarry (black) stools	☐	☐
Vomiting	☐	☐
Ulcers	☐	☐
Hepatitis	☐	☐
Colitis	☐	☐
Crohn’s	☐	☐

6. HEMATOLOGIC:	Yes	No
Anemia	☐	☐
Easy to bruise	☐	☐
Ever had blood transfusion	☐	☐
Free bleeding/problems clotting	☐	☐

7. INTEGUMENTARY (Skin/Breast):	Yes	No
Breast mass /lump	☐	☐
Breast pain	☐	☐
Enlargement of lymph nodes	☐	☐
Nipple discharge	☐	☐
Rash or Itching	☐	☐

8. MUSCLE, JOINT, BONE:	Yes	No
Joint swelling	☐	☐
Muscle cramp with walking	☐	☐
Muscle weakness	☐	☐

Review of Systems

Lubbock Surgical Associates, LLP

9. NEURO:	Yes	No
Blackouts	☐	☐
Headaches	☐	☐
Memory loss	☐	☐
Seizures	☐	☐
Slurred Speech	☐	☐
TIA's/Stroke	☐	☐

10. PSYCHIATRIC:	Yes	No
Anxiety	☐	☐
Depression	☐	☐
Mood swings	☐	☐

11. RESPIRATORY:	Yes	No
Asthma	☐	☐
Cough productive	☐	☐
Cough up blood	☐	☐
Emphysema	☐	☐
Shortness of breath w/ exertion	☐	☐
TB	☐	☐
Blood Clots (lungs)	☐	☐

12. UROLOGIC:	Yes	No
Blood in urine	☐	☐
Burning with urination	☐	☐
Dark urine	☐	☐
Increased frequency	☐	☐
Loss of urine/incontinence	☐	☐
Strain to urinate	☐	☐
Urinating at night	☐	☐
Kidney infections/stones	☐	☐
Prostate problems	☐	☐

Female Only:	Yes	No
# of Deliveries: ________		
# of Pregnancies: ________		
Date of last menstrual period: ________		
Age at menopause: _______		
Ever take birth control pills:	☐	☐
How long___ yrs or mos		
Hormone replacement:	☐	☐
How long ____ yrs or mos		

____

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Patient or Guardian Signature: ________________________Date: _________________

Office Nurse Initials: _____________________ Date: _________________

Lubbock Surgical Associates, LLP

Patient Surgeries/Family History

Name: **Date:** **Account:**

PREVIOUS SURGERIES	DATE	DR. WHO PERFORMED SURGERY OR HOSPITAL
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Smoke: **Yes** **No** **Packs/Day:** **# Of Years**

Alcohol: **Some** **Frequent** **None** **# Of Years**

FAMILY HISTORY:	Yes	No	Relationship: (do not put yourself)
Alzheimer's Disease	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Heart disease	☐	☐	
High blood pressure	☐	☐	
Other	☐	☐	
Stroke	☐	☐	

LUBBOCK SURGICAL ASSOCIATES, L.L.P.

RELEASE OF INFORMATION

I hereby authorize Lubbock Surgical Associates, L.L.P. to disclose all or any part of my record to any person or corporation, which is or may be liable under a contract to Lubbock Surgical Associated or to me or to a family member, to pay any of my charges for services rendered. This includes but is not limited to hospital or medical service companies, insurance companies, review agencies contracted by the insurance company, workers compensation carriers, welfare or benefit funds, or the patient's or responsible party's employer.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby transfer and assign to Lubbock Surgical Associates all right, title and interest in any benefit payment due me for services rendered as provided in the policy(ies) of insurance of the named company or companies. I agree to pay the charges of Lubbock Surgical Associates, which may exceed the amount paid by the named insurance company or companies.

APPLIES TO MEDICARE AND/OR MEDICAID PATIENTS ONLY

I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. I authorize any holder of medical and other information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare and/or Medicaid claim. I request that payment of authorized benefits be made on my behalf to Lubbock Surgical Associates, L.L.P.

If I have Medicare Supplement Insurance, I hereby authorize Lubbock Surgical Associates, L.L.P. to release such information as noted above and submit claims to the supplemental insurance company. I request that payment of authorized benefits from the supplemental insurance company be made on my behalf to Lubbock Surgical Associates, L.L.P.

This form has been explained to me and I understand its contents.

____

Signature of Patient/Insured   Relationship to Patient

Patient Name (Printed)____

LUBBOCK SURGICAL ASSOCIATES, LLP

TED ALLEN, MD, FACS   DERICK HAGGARD, MD, FACS   DAVID MANGOLD, MD, FACS
SAMMY RIVAS, MD, FACS   RICHARD ROSEN, MD, FACS   TRAVIS D. EGGL, DO

NOTICE OF PRIVACY POLICY

I have received a copy of, read, and understand the Privacy Policy of Lubbock Surgical Associates, L.L.P. I understand my rights concerning how medical information about me may be used and disclosed and how I can get access to this information. I understand I have the right to complain to the Secretary of the Department of Health and Human Services and the privacy officer of Lubbock Surgical Associates, L.L.P. if I feel my privacy rights have been violated.

____ _____________
Signature Date

____
Relationship to Patient

LUBBOCK SURGICAL ASSOCIATES, L.L.P. AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name ____ Medical Record # ___________________________________

Date of Birth _______________________________ Social Security ________________________________

I authorize the following individual or organization to disclose the above named individual's health information:

____ Address: ____

This information may be disclosed TO and used by the following individual or organization:

Lubbock Surgical Associates, L.L.P.	Ted Allen, MD	Derick Haggard, MD	David Mangold, MD
3611 22nd Place	Sammy Rivas, MD	Richard Rosen, MD	Travis Eggl, DO
Lubbock, TX 79410 Fax: 806.771.2224			

For the purpose of ____

Please release the following:

_____ Problem List
_____ Progress Notes
_____ History/Physical Exam
_____ Medication List
_____ Immunization Record
_____ List of Allergies
_____ X-Ray/Imaging Reports - from (date) __________ to (date) __________
_____ XC-Ray Films
_____ Laboratory Results - from (date) __________ to (date) __________
_____ EKG Reports
_____ Other Diagnostic Reports (Specify) ____________________________________
_____ Other (Specify) ____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodefiency virus (HIV). It may also include information about behavioral or mental services, and treatment for alcohol and drug abuse.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:
____

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health information, I can contact Allison Mooney at 806.771.2222.

____ ______________________________
Signature of Patient or Legal Representative Date

____ ______________________________
Relationship to Patient (If Legal Representative) Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Lubbock Surgical Associates, L.L.P. liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

____ ______________________________
Signature of Patient or Legal Representative Date

____ ______________________________
Relationship to Patient (If Legal Representative) Witness