Name____Date of Birth______________

Please check if you are CURRENTLY having trouble with any of the following (check all that apply):

GENERAL

- ☐ Fever ☐ Chills. ☐ Sweats
- ☐ Headache/Migraine
- ☐ Decreased Appetite
- ☐ Fatigue
- ☐ Feeling Poorly (Malaise)
- ☐ Weight Loss

EYES

- ☐ Blurring
- ☐ Double Vision
- ☐ Irritation
- ☐ Discharge
- ☐ Vision Loss
- ☐ Eye Pain
- ☐ Light Sensitivity

EARS/NOSE/THROAT

- ☐ Earache
- ☐ Ear Discharge
- ☐ Ringing of the Ears
- ☐ Decreased Hearing
- ☐ Nasal Congestion
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Trouble Swallowing

HEART/VASCULAR

- ☐ Chest Pains
- ☐ Palpitations
- ☐ Fainting (Syncope)
- ☐ Painful Breathing with Exercise.
- ☐ Peripheral Vascular Disease.
- ☐ Swelling of Arms/Legs.

OTHER

- ☐ ______________________

GASTROINTESTESTIONAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea (5+loose stools daily).
- ☐ Constipation
- ☐ Change in Bowel Habits
- ☐ Abdominal Pain
- ☐ Black Stools (Melena).
- ☐ Blood in Stool
- ☐ Yellow Skin (Jaundice)

GENITOURINARY

- ☐ Vaginal Discharge
- ☐ Incontinence
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Urinary Frequency
- ☐ No Periods (Amenorrhea)
- ☐ Abnormal Menstrual Bleeding
- ☐ Pelvic Pain

MUSCULOSKELETAL

- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Stiffness
- ☐ Arthritis

NEUROLOGIC

- ☐ Transient Paralysis
- ☐ Weakness
- ☐ Parathesis (numbness)
- ☐ Seizures
- ☐ Passing Out (Syncope)
- ☐ Tremors
- ☐ Dizziness (vertigo)

RESPIRATORY

- ☐ Cough
- ☐ Painful Breathing
- ☐ Excessive Sputum
- ☐ Spitting up Blood
- ☐ Wheezing

SKIN

- ☐ Itching
- ☐ Dryness
- ☐ Suspicious Lesion
- ☐ Rash
- ☐ Cancer

PSYCHIATRIC

- ☐ Depression
- ☐ Anxiety
- ☐ Memory Loss
- ☐ Mental Disturbance
- ☐ Suicidal Thoughts
- ☐ Hallucinations
- ☐ Paranoid

ENDOCRINE

- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Excessive Thirst
- ☐ Excessive Hunger
- ☐ Excessive Urine
- ☐ Weight Loss

HEME/LYMPHATIC

- ☐ Abnormal Bruising
- ☐ Bleeding
- ☐ Enlarged Lymph Nodes

Name____Date of Birth________________

SURGICAL HISTORY (Please include approximate date and surgeon/facility)

1.____________________________________ 5. ____________________________________
2. ____________________________________ 6. ____________________________________
3. ____________________________________ 7. ____________________________________
4. ____________________________________ 8. ____________________________________

☐ Check if No Previous Surgeries

COLONOSCOPY

Have you ever had a Colonoscopy? ☐ No ☐ Yes Date ______________________________
Results ____
Facility____

Have you or a family member had any problems/reactions to anesthesia? ☐ Yes ☐ No
Have you or a family member had any problems with bleeding after surgery? ☐ Yes ☐ No

SOCIAL HISTORY

Alcohol: Do you drink alcohol? ☐ Never ☐ Occasionally ☐ Daily
If yes what kind? ☐ Beer ☐ Wine ☐ Liquor
Number of drinks per day? ________________

Tobacco: Do you currently use tobacco? ☐ Yes ☐ No
If yes how many years? ______________
What form of tobacco? ☐ Pipe ☐ Cigarettes ☐ Chew/Dip ☐ Cigar
Number per day? __________________
Quit?______________ Quit Date?_____________
Does anyone in your household smoke? ☐ Yes ☐ No

Drug Use: (do not include prescription or OTC medications) ☐ Never ☐ Previous History ☐ Occasionally ☐ Daily
Uses per week?__________Uses per day?_____________Types of Drugs?____________

☐

FOR FEMALE PATIENTS ONLY

Date last Menstruated_________________________Menapause______________Age__________
Any Menstrual problems: ☐ Yes ☐ No Period every _______________days
Number of Pregnancies__________Number of Births__________Number of Miscarriages_________
Check if you have had: ☐ D and C ☐ Hysterectomy (partial/complete) ☐ Toxemia

WHEN WAS YOUR LAST MAMMOGRAM____

WHICH FACILITY WAS YOUR LAST MAMMOGRAM PERFORMED_____________________________

Name____Date of Birth______________

MEDICAL HISTORY (check all that apply)

☐ Coronary Artery Disease	☐ Hepatitis	☐ Aneurysm
☐ Congestive Heart Failure	☐ Cirrhosis	☐ Stroke or TIA
☐ Atrial Fibrillation	☐ Pancreatitis	☐ Carotid Artery Disease
☐ Hypertension	☐ Peptic Ulcer Disease	☐ Varicose Veins
☐ Heart Valve Disease	☐ Colon Polyps	☐ Leg Pain with Walking
☐ COPD	☐ Diverticulosis/Diverticulitis	☐ DVT/Blood Clots
☐ Tuburculosis	☐ High Cholesterol	☐ Pulmonary Embolism
☐ Asthma	☐ Diabetes	☐ Bleeding Disorder
☐ Blood in Stool	☐ Renal Disease or Failure	☐ Anemia
☐ Constipation	☐ Kidney or Urinary Infection	☐ Rheumatic Disease
☐ Diarrhea	☐ Thyroid Disease	☐ Ostoarthritis
☐ Irritable Bowel Syndrome	☐ Depression or Anxiety	☐ Osteporosis
☐ GERD/Heartburn	☐ Seizures	☐ Cancer ____________
☐ Chrohns Disease/Ulcerative Colitis	☐ Galucoma	☐ __________________

FAMILY CANCER HISTORY

Please list your family members relation to you and their age at cancer diagnosis. *(first degree relative = Mother, Father, Sister, Brother, Children)*

Uterine Cancer ____Personal History ☐
Colon/Rectal Cancer_ ____Personal History ☐
Stomach Cancer ____Personal History ☐
Small Bowel Cancer____Personal History ☐
Colon Polyps____Personal History ☐
Breast Cancer____Personal History ☐
Ovarion Cancer____Personal History ☐
Pancreatic Cancer____Personal History ☐
Skin Cancer____Personal History ☐

Is there any other cancer in a family member that is not listed above? Please list their relation and age at diagnosis here:____
____
____

Name____Date of Birth______________

FAMILY MEDICAL HISTORY:
Please list any diseases that run in your family and relation
(example, heart disease, stroke, bleeding disorders)

____
____
____
____

ALLERGIES
☐ **I have No Know Allergies to drugs / medications.**

Are you sensitive/allergic to **LATEX**? ☐ Yes ☐ No **SHELLFISH** ☐ Yes ☐ No **IODINE** ☐ Yes ☐ No

Please list any know drug allergy

	Allergy	Type of Reaction	Severity (Very Mild, Mild, Moderate, Severe)
1			
2			
3			
4			
5			
6			

MEDICATIONS
Do you Take any medications? ☐ Yes ☐ No
If you answered yes, please list your medications on the sheet provided.

Preferred Pharmacy____

*Do you take Aspirin? ☐ Yes ☐ No **Do you take a blood thinner? ☐ Yes ☐ No

	Name of Medication	Dose	How often taken	Reason Taken
1.				
2.				
3.				
4.				
5.				
6.				
8.				
9.				
10.				

PATIENT INSURANCE/PERSONAL INFORMATION

Thompson Surgical Associates will bill your insurance carrier if proper coverage verification is received. Please complete the required insurance information and acknowledgement fields below, as well as the insurance and financial policies page attached. Please include **a front and back copy of your primary insurance card to the front desk.**

I. Patient Name ______________________ **DOB** ______________

Address: ____

City: __________________ **State** ______ **Zip** ______________

Preferred Phone# ________________ **Additional Phone#** ______________

Marital Status (circle one) Single Married Divorced Widowed Other

Preferred Contact Method (circle one) Phone Email Is it okay to leave a voicemail? Yes/No

Social Security # (required) ____________

***EMAIL** ________________________

***PRIMARY CARE PHYSICIAN** ____________________

II. Person Responsible for Insurance Account: ______________________

Relation to Patient __________ **DOB** __________ **Soc. Sec. #** ______________

Address (If different from patients) ______________________________

City ____________ **State** ____ **Zip** __________ **Phone #** ______________

Ins. Company ______________ **Contract #** ____________ **Group#** ________

III. Name of Secondary Ins. Company ______________________

Contract # ______________ **Group #** ______________

Insured's Name (if different from Patient) ______________________

Relation to Patient __________ **DOB** __________ **Soc. Sec #** ____________

PATIENT RESPONSIBILITY ACKNOWLEDGEMENT & ASSIGNMENT AUTHORIZATION:

1. I understand that I am financially responsible for all charges not paid by my insurance, with payment expected from me ***within 30 days of statement notification.*** I understand that non-compliance with payment terms can immediately result in my forfeiture of any and all insurance billing options extended to me by Thompson Surgical Associates.
2. I authorize release of information in my medical history to my insurance company and assign all benefits for unpaid services to my doctor at Thompson Surgical Associates. A photo static copy of this authorization shall be considered as effective as the original. Assignment will remain in effect until revoked by me in writing.

Patient Signature: ______________________ **Date:** ______________

Insurance and Financial Policies Thompson Surgical Associates:

1. Insurance: _____Initial

Some providers participate or contract with certain insurance companies. If we do not participate with your particular insurance company at the time, we may still be able to bill as an out-of-network provider. Knowing your insurance coverage is **your responsibility** - please contact them with questions about your coverage **before your visit.**

In some cases, care agreed to be medically indicated by the physician and the patient may not be covered by insurance (for example: lab work-up, annual exams, pre-existing conditions, IV Therapy) and you will be required to pay for those services. Please check with your insurance company to find out if there are any exclusions in your individual policy. It is important to understand that a verbal confirmation of coverage over the phone from the insurance company does not guarantee payment by them. As is not uncommon for an insurance company to misquote a policy, we recommend reviewing your policy to confirm that the information we received is correct. It is the patient's responsibility to follow up if a claim is not paid. Please be aware that you are responsible for the balance of your claim as decreed by your insurance company.

2. Co-Payments and Deductibles: ______Initial

By signing this agreement you agree to pay your copay, co-insurance and /or deductible and any fees that your insurance company does not cover. Copays or co-insurance is an arrangement between you and your insurance company. Failure on our part to collect copays, co-insurance and deductibles from patients could be considered fraud. Please be informed about your copays, co-insurance and deductibles.

3. Proof of Insurance: ______Initial

All patients with insurance coverage must complete the patient intake forms and provide current valid insurance card. This card will be copied and stored with your patient chart. If insurance coverage changes or expires please provide a current card as soon as it is issued.

4. Self Pay: ______Initial

If you do not have insurance, payment in full is expected prior to services rendered.

5. Non-Payment ______Initial

If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, your account may be referred to a collection agency and charged a processing fee of $75 and you and your immediate family members may be discharge from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis. It is your responsibility for all fees incurred to obtain payment. **There is a $35.00 fee for returned checks to cover bank fees.**

Authorization:

- I have read the above 2 pages of information and agree regardless of my insurance status to be responsible for the balance of my account. I agree to pay for all services rendered not covered by my insurance and to notify this office should there be any changes to my insurance coverage.

AND

- I authorize the release of any medical or other information necessary to process any claims

AND

- I authorize payment of medical benefits to my Thompson Surgical Associates/Jeffrey Thompson M.D.

NAME (print) ______________________________ **SIGNATURE** ______________________________ **DATE** __________

IN CASE OF EMERGENCY who should be notified: ____________________ **Phone#** ________________

Person/Persons you are allowed to share my medical information with: ______Initial

Name ____ **Phone #:** ______________________

Name ____ **Phone #:** ______________________

Name ____ **Phone #:** ______________________