

PATIENT # _____

LSG 001

LANCASTER SURGICAL GROUP, P.C.

PATIENT INFORMATION (PLEASE PRINT)

DATE _____

Patient's Name(above line) Social Security No. Home Phone # Driver's License #

Street Address City, State and Zip Code Cell Phone # Marital Status Date of Birth

Patient's Employer, Occupation and Address Employer Phone No.

Spouse's Name (If Applicable) Social Security No. Spouse's Employer Phone No.

Spouse's Employer, Occupation and Address

Spouse's Address (if different)

Emergency Contact Street Address City, State and Zip Code Phone # Relationship

Work Related Injury/Illness? Date of Injury Date Reported to Employer

Work Injury Description of Occurrence

INSURANCE INFORMATION (PLEASE COMPLETE FULLY)

PRECERTIFICATION AND/OR SECOND OPINIONS ARE THE PATIENTS RESPONSIBILITY, PLEASE INFORM US OF ANY SUCH REQUIREMENTS SO THAT WE MAY ASSIST YOU IN MEETING THESE REQUIREMENTS.

DOES YOUR INSURANCE REQUIRE: PRE-CERTIFICATION: YES NO SECOND OPINION: YES NO

MEDICARE # (If Applicable) _____ MEDICAL ASSISTANCE #(If Applicable) _____ / / / / /

PRIMARY

Name and Address

Policy Number Group Number Insured Name, **Date of Birth** & Relationship to Patient

SECONDARY

Name and Address

Policy Number Group Number Insured Name, **Date of Birth** & Relationship to Patient

COMPLETE THIS SECTION IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR BILL.

Responsible Party Name and Address

Home Phone Number

(Please complete the back side)

Work Phone Number

_____ CARD COPIED

PATIENT INFORMATION (CONTINUED)

REFERRING INFORMATION

How did you find out about our practice? _____

Requesting Doctor Name and Address

Family Doctor Name and Address (if different than requesting Doctor)

General Comments

AUTHORIZATION FOR RELEASE OF INFORMATION: By listing any name you are hereby expressly permitting us to discuss and/or disclose your personal/individual protected health information with the stated individual(s) until such time as you inform us in writing that permission is no longer granted. Initials _____

Name(s)

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare Benefits be made on my behalf to LANCASTER SURGICAL GROUP, P.C., for any services furnished to me by that group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient Signature (for Medicare Lifetime signature file) _____
Date

PRIVATE INSURANCE AUTHORIZATION

I, the undersigned authorize payment of medical benefits to LANCASTER SURGICAL GROUP, P.C., for any services furnished to me by that group. I understand I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Patient (And / Or Responsible Party) Signature _____
Date

GENERAL POLICIES

Fees for office visits and procedures are payable at the time of visit. Please be prepared to pay by Cash, Personal Check or Visa/MasterCard. This policy is for all insurance plans except for those plans specifically excluded by contractual relationship with Lancaster Surgical Group, P.C.

Patient account collection efforts that result in collection agency costs/fees will result in the agency costs/fees being added to the balance due.

IF YOU HAVE ANY QUESTIONS, PLEASE ASK!

Name _____ DOB _____ DATE _____ NEW PT EST PT NEW PRBLM CONSULT**HISTORY – COMPLETED BY PATIENT, STAFF OR PROVIDER**

1. Reason for visit today _____

2. Patient evaluated at the request of _____ Work Related3. Please indicate with if you have a history of or any current problems or symptoms in any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> General Wellness | <input type="checkbox"/> Heart/Circulation | <input type="checkbox"/> Blood/Lymph |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Skin | <input type="checkbox"/> Atrial Fib | <input type="checkbox"/> TB |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hypertension | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> Psychiatric | <input type="checkbox"/> HighChlstrl/Lipids | <input type="checkbox"/> Neurological |
| <input type="checkbox"/> Ears,Nose,Throat | <input type="checkbox"/> Stomach/Digestion | <input type="checkbox"/> Stroke/Seizure |
| <input type="checkbox"/> Lungs/Breathing | <input type="checkbox"/> Bowel | <input type="checkbox"/> Thyrd/Endocrine |
| <input type="checkbox"/> MuscleJoint/Bone | <input type="checkbox"/> Reproductive/Urinary | <input type="checkbox"/> Diabetes |

Comments – Review of Systems

 All other systems negative

4. Medication(s) (drugs, pills): _____

5. Previous Surgeries/Dates: _____

(attach sheet if necessary)

6. Allergies/Reaction _____

7. What is your Social History

Marital Status: Single, Divorced, Married, Widow/Widower, Who lives with you? _____

Current Employer/Occupation? _____ What kind of work(lifting on feet)? _____

Do you smoke? _____ How many packs a day? _____ For how many years? _____

Do you drink alcohol? _____ #drinks per day? _____ per week? _____ per month? _____ Illicit Drug Use? _____ What Type? _____

8. What is the Health Status of Your Family?

Mother: _____ Father: _____

Brothers/Sisters: _____

Family Illnesses:History of Heart Disease(heart attack, heart failure) yes no History of Strokes? yes noHistory of high blood pressure? yes no History of diabetes?yes no History of cancer?yes, site _____ no**HISTORY – COMPLETED BY PROVIDER**

Chief Complaint: _____

History of Present Illness: (Location, Quality, Timing, Severity, Duration, Context, Modifying Factors, Assoc. signs/symptoms) (1-3 brief, 4+ extended) OR Status of Chronic or Inactive Conditions (3 or more = extended w/o HPI)