PHYSICIANS SURGERY CENTER

Date

Patient Information

Age	Sex	Race

Last Name	First Name	MI

Address	City	State	Zip Code

Home Phone	Work Phone	Cell Phone	Date of Birth	Marital Status

Social Security Number	Email Address

Employer	Emergency Contact Number

Insurance Information

(Skip, If Worker's Comp or Liability)

Primary Insurance Name	Policy Holder's Name	Policy Holder's DOB

Policy #	Group #	Relationship of Policy Holder to Patient

Secondary Insurance Name	Policy Holder's Name	Policy Holder's DOB

Policy #	Group #	Relationship of Policy Holder to Patient

IF PATIENT'S A MINOR, PLEASE FILL OUT THIS SECTION

Parent's Full Name	Address(If Different)	Parent's Social Security No.	

Parent's DOB	Home Phone	Work Phone	Cell Phone

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I understand that I have rights regarding my protected health information. These rights are governed by the Health Insurance Portability and Accountability Act of 1996. HIPAA I have been informed and given the opportunity to review and secure a copy of the facility's Notice of Privacy Practice which contain a more complete description of the uses and disclosures of my protected health information.

I hereby authorize the release and disclosure of my protected health information for treatment or payment for health care operations. I understand that any and all records concerning my personal and medical history are the confidential property of Physicians Surgery Center.

I agree that Physicians Surgery Center may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

I also agree that by providing my cell phone number I am giving consent for Physicians Surgery Center to contact me by this phone number.

You may restrict the individuals or organizations to which your health care information is released and you may revoke your authorization to us at any time, however, your revocation must be in writing and delivered to our address.

_____ _____

Signature of Patient/Guardian/Responsible Party Date
(Must be 18 years of age or older)

CONSENT OF FINANCIAL RESPONSIBILITY

My insurance policy is a contract between my insurance carrier and myself. I am ultimately responsible for payment-in-full for all medical services provided to me. I acknowledge full responsibility for services rendered by Jackson Ophthalmology ASC LLC dba Physicians Surgery Center. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements are made prior to treatment. I agree to pay all collection and attorney fees, if applicable, in the event of default of payment of charges. I assign benefits to and authorize direct payment to Jackson Ophthalmology ASC LLC dba Physicians Surgery Center of which it is entitled. This also includes proceeds and benefits accruing under any settlement, structure or otherwise, or awarded in judgment for personal injuries caused by a third party for payment of services rendered by Jackson Ophthalmology ASC LLC dba Physicians Surgery Center. I agree to pay for all charges not paid pursuant to this agreement. I agree, in order for Jackson Ophthalmology ASC LLC dba Physicians Surgery Center and/or any of its Business Associates to service my account or to collect any amount I may owe Jackson Ophthalmology ASC LLC dba Physicians Surgery Center or any of its Business Associates, they may contact me at any telephone number associated with my account, including cellular numbers, which may result in charges to me. I may also be contacted by text message or email, using only the email address I provide. Methods of contact may include prerecorded/artificial voice messages and/or use of an automated dialing service.

_____ _____

Signature of Patient/Guardian/Responsible Party Date
(Must be 18 years of age or older)

I understand that Jackson Ophthalmology ASC LLC dba Physicians Surgery Center will always attempt to resuscitate the patient and refer the patient to another facility which provides a higher level of care if necessary.

Organ Donor: Yes or No Living Will: Yes or No

_____ _____

Signature of Patient/Guardian/Responsible Party Date
(Must be 18 years of age or older)

PHYSICIANS SURGERY CENTER
PREOPERATIVE EVALUATION

Sex (Circle): M F Age:_____ Height:_____ BMI:_____ Weight:_____

Proposed Surgical Procedure: _____

Previous Surgery:_____

_____

Prior Anesthesia Complications or Family History of Anesthesia Complications: □ Yes □ No Comments:_____

_____

HISTORY Check "Yes" or "No"

General:_____

Glaucoma	□ Yes	□ No
Serious Illness	□ Yes	□ No
Dentures	□ Yes	□ No
Bleeding Problems	□ Yes	□ No
Hearing Loss	□ Yes	□ No
Alcohol/Drug Abuse	□ Yes	□ No
Smoke _____ Packs	□ Yes	□ No
Anemia	□ Yes	□ No
Arthritis	□ Yes	□ No

Cardiovascular:_____

Heart Attack	□ Yes	□ No
High Blood Pressure	□ Yes	□ No
Angina	□ Yes	□ No
Congestive Heart Failure	□ Yes	□ No
Poor Circulation	□ Yes	□ No
Coronary Artery Disease	□ Yes	□ No
Pacemaker	□ Yes	□ No
Defibrillator	□ Yes	□ No
Irregular Heart Beat	□ Yes	□ No
Atrial Fibrillation(Afib)	□ Yes	□ No
DVT/PE/Bloodclots	□ Yes	□ No

Respiration:_____

Pneumonia	□ Yes	□ No
Asthma	□ Yes	□ No
Emphysema/COPD	□ Yes	□ No
Recent Upper Resp. Infection	□ Yes	□ No
Shortness of Breath	□ Yes	□ No
Tuberculosis	□ Yes	□ No
Oxygen Use/CPAP	□ Yes	□ No

GI:_____

Liver Disease	□ Yes	□ No
Stomach Problems	□ Yes	□ No

GU:_____

Frequent Kidney Infections	□ Yes	□ No
Renal Failure	□ Yes	□ No
Kidney Disease	□ Yes	□ No
Dialysis	□ Yes	□ No

Claustrophobia	□ Yes	□ No
Sleep Apnea/CPAP	□ Yes	□ No

Metabolic:_____

Diabetes	□ Yes	□ No

Type I □ Type II □

Age of Onset:_____

Rx Oral:_____

Insulin:_____

Insulin Pump:	□ Yes	□ No

Neurology:_____

Epilepsy/Seizures	□ Yes	□ No
Frequent Headaches	□ Yes	□ No
Difficulty Walking	□ Yes	□ No
Dizziness	□ Yes	□ No
Back/Neck Disorder	□ Yes	□ No
Stroke	□ Yes	□ No

Cancer History:_____

_____

_____

Have you ever been diagnosed with:
HIV □ VRE □ MRSA □ Hepatits □

Current Medical Doctor:_____ Date of Last Physical Exam:_____

Staff Use Only Below This Line

**Prescription for Emend 40mg PO given to general anesthesia patients to take the morning of their surgery per anesthesia protocol □ Yes □ No □ NA

Patient or Guardian Signature_____ Date:_____

Nurse Signature:_____ Date:_____

BP:_____ HR:_____ O2:_____ T:_____

Allergies: _____ Reaction: _____
Allergies: _____ Reaction: _____
Allergies: _____ Reaction: _____
Allergies: _____ Reaction: _____
Allergies: _____ Reaction: _____

Medications:	Dosage	Frequency	Take Morning of Surgery		Continue After Discharge	
			YES	NO	YES	NO

Pre-Admission Nurse:_____ Date:_____

Discharge Nurse:_____ Date:_____

MD Signature:_____ Date:_____