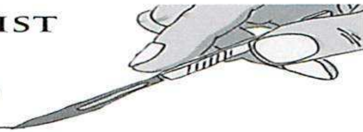
GRAND BLANC SURGICAL SPECIALIST

8384 HOLLY ROAD - SUITE 1
GRAND BLANC, MI 48439
PH: 810.733.8400 FX: 810.579.7260
WWW.GBSURGICALSPECIALIST.COM



SS#__ __ __ __ __ __ __ __ __ DOB __ __/ __ __/ __ __ Gender Male Female Marital Status S M D W

Last ____________________ MI _____ First ____________________ Suffix ________ AKA _______________

Street______________________________ City __________________ State ________ ZIP_____________

Home (__ __ __) __ __ __-__ __ __ __ Cell (__ __ __) __ __ __-__ __ __ __ Work (__ __ __) __ __ __-__ __ __ __

Email ____________________________@_______________.com Spouse Name ________________________

Emergency Contact ______________________ Phone (__ __ __) __ __ __-__ __ __ __ Relation ____________

Employer ____________________ Status ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Active Military

Preferred Hospital ☐ Genesys ☐ McLaren ☐ Hurley ☐ Other __________ Preferred Lab __________

Preferred Pharmacy __________________________________ Location ______________________________

How did you hear about us? ☐ Family ☐ Friend ☐ Internet/web site ☐ Doctors ☐ Hospital ☐ Other

Family Doctor ____ Phone (__ __ __) __ __ __-__ __ __ __

Referring Doctor ____ Phone (__ __ __) __ __ __-__ __ __ __

PRIMARY INSURANCE INFORMATION

Insurance Carrier ____ Phone (__ __ __) __ __ __-__ __ __ __

Enrollee ID/Policy # _________________________________ Group # ______________________ Plan _______

Subscriber Name ____ DOB __ __/__ __/__ __ __ __

Relationship ________________ Effective Date __ __/ __ __/ __ __ Termination Date __ __/ __ __/ __ __ __ __

SECONDARY INSURANCE INFORMATION

Insurance Carrier ____ Phone (__ __ __) __ __ __-__ __ __ __

Enrollee ID/Policy # __________________________________ Group # _____________________ Plan _______

Subscriber Name ____ DOB __ __/__ __/__ __ __ __

Relationship ________________ Effective Date __ __/ __ __/ __ __ Termination Date __ __/ __ __/ __ __ __ __

RESPONSIBLE PARTY INFORMATION Check here if same as patient ☐

Last Name ____________________ MI ____________ First ______________________ DOB __ __/__ __/__ __

Street ______________________________ City ____________________ State ________ Zip _____________

SS# __ __ __-__ __ -__ __ __ __ Employer ___________________________________ Phone (__ __ __) __ __ __-__ __ __ __

I agree that the information supplied on this form is accurate and up to date to the best of my knowledge.

Patient (or responsible party) Signature ____ Date __ __/__ __/__ __

HISTORY OF PRESENT ILLNESS

Name: ____________
DOB: ___/___/___

Why are you being seen today? ____

____

How long have you had this problem? ____

____

What are your symptoms? ____

____

Has the problem worsened since it first appeared? [ ] YES [ ] NO

If yes, describe ____

____

Is this a result of any of the following? [ ] Injury [ ] Sickness [ ] Pregnancy [ ] Other

If yes, describe ____

____

PAIN EVALUATION

What test have you had done in relationship to this problem? [ ] No test performed

[ ] CT SCAN Date________________ Location________________

[ ] MRI Date________________ Location________________

[ ] X-RAY Date________________ Location________________

[ ] ULSTRASOUND Date________________ Location________________

[ ] COLONOSCOPY Date________________ Location________________

[ ] BIOPSY Date________________ Location________________

[ ] OTHER ____________ Date________________ Location________________

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Zouhier Fares D.O., FACOS

Kiet Doan, D.O., FACOS

MEDICAL HEALTH HISTORY FORM

Name: ___________________

CURRENT MEDICATIONS

DOB: __ __/__ __/__ __

☐ **Check here if you have NO Medications to report**

Please list ANY prescribed medications, over the counter medications, herbal medication, vitamins, and dietary supplements that you are currently taking.

Name of Drug	Strength	Dosage	How often	Reason

ALLERGIES

☐ **Check here if you have NO ALLERGIES to report**

Are you allergic to LATEX? ☐ YES ☐ NO

Are you allergic to IODINE? YES ☐ NO ☐

Have you or a family member ever had a reaction to anesthesia? ☐ YES ☐ NO

Drug Allergy	Reaction

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SOCIAL HEALTH HISTORY

Name ___________________

DOB: __ __/ __ __/ __ __

Do you now, or have you ever used tobacco? ☐ YES ☐ NO If Yes, How Long _____ Packs per day _____ Year Quit___

Do you now, or have you ever used alcohol? ☐ YES ☐ NO If Yes, How often _____ How much _______ Year Quit___

Do you now, or have you ever consumed caffeine? ☐ YES ☐ NO If yes, How often _____ How much _______

Do you now, or have you ever used recreational drugs? ☐ YES ☐ NO

Surgical History

TELL US ABOUT YOUR PAST SURGICAL HISTORY: **Check here if no surgical history** ☐

TYPE OF SURGERY	PERFORMING SURGEON	DATE

Family History

TELL US ABOUT YOUR PAST FAMILY HISTORY: **Check here if you have no family history** ☐

FAMILY HISTORY: Please indicate family members having any of the following illness.

Illness	Father	Mother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Siblings Brother	Sister	Children
Obesity (278)									
Diabetes (250.00)									
High Blood Pressure (401)									
Heart Disease (429.9)									
Cancer/Type (V16.9)									
Seizures (345)									
Breathing Problems (786.9									
Kidney Disease (593.9)									
Arthritis (056.71)									
Early Death & Cause									
Other									

Review of Symptoms

Name____________________

DOB: _____/______/_____

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS? PLEASE CHECK ALL THAT APPLY **NONE APPLY** ☐

General
- ☐ Tiredness 780.7
- ☐ Fever 780.6
- ☐ Lack of appetite 783.0
- ☐ Night sweats 780.8
- ☐ Weight loss 783.21
- ☐ Weigth gain 783.1
- ☐ Chills 780.4
- ☐ Difficulty sleeping 780.52

Heent
- ☐ Headache 784.0
- ☐ Decreased Vision 368
- ☐ Spots before your eyes 368.10
- ☐ Hoarseness 784.40
- ☐ Decreased Hearing 389.9
- ☐ Blurred/double vision 368.8
- ☐ Ringing of the ears 388.30

Cardiovascular
- ☐ Chest pain/tightness 786.59
- ☐ Black out episodes 780.2
- ☐ Varicose veins 454.1
- ☐ Shortness of breath(Lying) 786.05
- ☐ Racing Heart 427.89
- ☐ Irregular heart beat 427
- ☐ Swelling of the legs 782.3
- ☐ Discoloration of hands/feet 782.9

Respiratory
- ☐ Difficulty breathing 786.03
- ☐ Coughing of Phlegm 786.2
- ☐ Coughing of blood 786.3
- ☐ TB history V12.01
- ☐ Dry cough 786.2
- ☐ Wheezing 786.07
- ☐ Asthma 493.9

Gastrointestinal
- ☐ Nausea 787.02
- ☐ Vomiting 787.03
- ☐ Red blood in stool 578.1
- ☐ Change in bowel habit 787.99
- ☐ Abdominal pain 789.00
- ☐ Black stool 792.1
- ☐ Vomiting of blood 578.0
- ☐ Need for antacids 530.11

Urinary
- ☐ Blood in urine 599.70
- ☐ History of stones 592.0
- ☐ Painful urination 788.1

Musculosketal
- ☐ Muscle pain 729.1
- ☐ Loss of muscle mass 729.89
- ☐ Muscle weakness 728.87
- ☐ Painful/Stiff joints 719.40

Skin
- ☐ Rash 782.1
- ☐ Itching 691.8
- ☐ Easy bruising 924.9
- ☐ Skin ulcers 707.09

Neurological
- ☐ Seizures 345.1
- ☐ Blindness 369.00
- ☐ TIA (Mini Strokes) 435.9
- ☐ Tremors 781.0
- ☐ CVA (Stroke) 436
- ☐ Difficulty w/ thinking 294.9
- ☐ Dizziness 438.85

Endocrine
- ☐ Goiter 240.9
- ☐ Heat/Cold Intolerance 780.99
- ☐ Change in voice pitch 784.49
- ☐ Tremulousness of hands 333.1

Psychiatric
- ☐ Depression 311
- ☐ Schizophrenia 295.9

Breast
- ☐ Lumps 611.72
- ☐ Pain 611.71
- ☐ Discharge 611.79

TELL US ABOUT YOUR PAST MEDICAL HISTORY:

NO PAST MEDICAL HISTORY: ☐

Please check all that apply

Neurological
- ☐ Aneurysm 442.09
- ☐ Neurological Disease 349
- ☐ Migraine 346.9
- ☐ Concussion 850.9
- ☐ Epilepsy 345.9
- ☐ Stroke/TIA 435.9
- Other__________

Endocrine
- ☐ Diabetes: 250.0
  - ☐ Type I
  - ☐ Type II
- ☐ Thyroid Disorder 246.8

Pulmonary
- ☐ Pulmonary embolus 415.1
- ☐ Emphysema 492
- ☐ COPD 518.89
- ☐ Asthma 493.9
- Other ____________

Hepatic
- ☐ Liver Disease571.9

Infectious
- ☐ HIV 042
- ☐ TB 010.00
- ☐ Hepatitis A/B/C 573.3
- Other______________

Gastrointestinal
- ☐ Refulx/GERD 530.81
- ☐ Stomach ulcer 533
- Other__________

Renal
- ☐ Kidney disease 593.9
- ☐ Kidney stones 592.00
- Other__________

Cancer
- ☐ Specific Type

____

____

____

Cardiovascular
- ☐ Coronary artery disease 414.01
- ☐ Past Heart Surgery 414.05
- ☐ Heart Murmur 785.2
- ☐ High cholesterol 272.2
- ☐ DVT/Blood clot 453.9
- ☐ High Blood pressure 401
- ☐ Defibrillator Implanted V45.02
- ☐ Pacemaker Implanted V45.01
- ☐ Arrhythmia/irregular heart beat 427.9
- ☐ Heart valve dysfunction 424.1

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AUTHORIZATION FOR USE OF DISCLOSURE OF HEALTH INFORMATION

I ______________________________________ Date of Birth __ __/__ __/__ __

hereby authorize **Grand Blanc Surgical Specialist and authorized staff,** to disclose all medical records including alcohol and drug abuse records protected under the regulations in 42 Code of Federal regulation, Part 2, if any; social services records, in any; and psychological services records, if any; including communications made by me to any employee of this office; or any records pertaining to my HIV infection, acquired immunodeficiency syndrome or acquired immunodeficiency syndrome related complex or a test for any such disease, including records protected under Act 488, Public Acts of Michigan, 1988, if any; or any other records or test related to any other sexually transmitted disease, if any; which may be contained within the records specified below.

FOR OFFICE USE ONLY: THE FACILITY INFORMATION WILL BE ENTERED WHEN INFORMATION IS REQUESTED

You must list specific information to be disclosed including from and to dates. (ex: radiology, laboratory, dictation, etc)

______________________________ From: __ __/__ __/__ __ To: __ __/__ __/__ __

______________________________ From: __ __/__ __/__ __ To: __ __/__ __/__ __

______________________________ From: __ __/__ __/__ __ To: __ __/__ __/__ __

The above protected health information may be disclosed to and used by the following individual or entity.

Name GRAND BLANC SURGICAL SPECIALIST

Address: 8384 HOLLY RD SUITE 1 City: GRAND BLANC State: MI ZIP: 48439

Phone: (810) 733-8400 Ext 0 Fax: (810) 579-7260 WEB: www.gbsurgicalspecialist.com

This protected information is being disclosed for the following purpose, Medical Evaluation & Treatment

This authorization shall be in force and effect for one year from the signature date.

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 by presenting my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurance with the right to contest a claim under my policy.

I understand that information used or disclosed pursuant to this authorization may be subject to the re-disclosure by the recipient and may no longer be protected by federal or state law. 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, they may be directed to the privacy officer contact.

Signature of Patient: ______________________________ Date/Time: ______________

If patient is unable to sign or is a minor, complete the following;

Signature of Legal Representative ______________________________ Date/Time: ______________

Witness: ______________________________ Date/Time: ______________

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PERSONAL RECORDS REQUEST AUTHORIZATION

Patient Name ____ Date: __ __/__ __/__ __

This is to verify that I would like the following person(s) to be allowed access to my medical records from this medical office, as described below.

Name Date of Birth Relation

1. ____

2. ____

3. ____

I hereby authorize this office to release the following information to the above named person(s)

Please write YES or NO in the spaces provided to determine what if any information you authorize to be disclosed.

_______ Appointment Date/Time

_______ Reports (X-Ray, Operative Reports, Pathology, Labs, etc.)

_______ Consultation and or Dictation Letter

_______ Billing/Accounting Information

Please circle ONE

May we leave a detailed message on your voicemail and/or answering machine?

YES NO

May we forward you information and/or records to other providers that you are currently a patient of and /or physicians that we may refer you to?

YES NO

By signing this authorization you are consenting to the disclosure(s) that you described above.

Patient Signature ____ Date: __ __/__ __/__ __

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PATIENT FINANCIAL AGREEMENT

PLEASE READ THOROUGHLY AND SIGN BELOW

In consideration of the receiving services from Grand Blanc Surgical Specialist, you agree:

1. All services are provided to you with the understanding that you are responsible for the cost regardless of your insurance coverage. If you would like to know the cost of a service please inquire prior to treatment. Please be aware that not all services are a covered benefit with different insurance companies. You are responsible for knowing what services are or are not covered. **KNOW YOUR BENEFITS.**

2. You are responsible for knowing if a referral is required. Make sure you know what physicians are in your plan, what facilities are covered and what ancillary services you must use (such as laboratory, hospitals, etc.) If we can be of assistance, please let us know.

3. Upon check in we will collect your deductible, co-pay and payment for any uncovered services as well as the patient's portion as determined by insurance. We accept cash, check and/or credit (Visa, American Express, Discover & MasterCard).

4. **Returned checks are subject to a $25.00 return check fee.**

5. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to contact. It is your responsibility to inform our office of insurance coverage or company changes immediately.

6. We will bill your insurance company once, as a courtesy, but you are ultimately responsible for payment of all services you receive. If your insurance company does not respond within 30 days we will follow up with an inquiry on your behalf; however if your insurance does not respond within 60 days of claim submission, a statement will be sent to you. You should call your insurance to question why the claim is not paid. Our office will assist you only after you have contacted your insurance; however, you must understand you cannot delay payment while you are awaiting the outcome of your complaint.

7. Any unpaid charges over 90 days will be turned to an outside collection agency with additional collection agency fees. You are responsible for any collection fees, legal fees, or court costs incurred in the collections process. This agency will report your failure to pay to the THREE (3) national credit reporting agencies.

8. Knowing the importance of your personal credit standing, we do understand that temporary financial hardships may affect timely payments. We encourage you to communicate any such hardships to our staff to ensure the assistance and proper management of your account. This communication will help to ensure any negative reports to your credit rating.

Due to the nature of the office schedule and patient courtesy, there will be a minimum charge of $25.00 for all cancelled appointments not given a 24 hour notice of cancellation. Furthermore, patients who fail to notify our office, fail to reschedule and/or fail to appear for a surgical procedure, will be charged a fee of $50.00. Please contact the office during normal business hours of 8:30am-5:00pm Monday-Thursday & 8:30am-4:00pm Friday, closed Saturday and Sunday.

If necessary please leave a message to ensure this fee will not be applicable. Our office will gladly assist you in re-scheduling an appointment given this policy is honored. Remember these charges are NOT BILLABLE to your insurance company. This is your full responsibility.

Patient/Guardian Signature ______________________________ Date __ __/__ __/__ __

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FEMALE HEALTH HISTORY

(For Women Only)

Name: ______________________

Date of Birth: __ __ / __ __ / __ __

The information asked on this form is strictly confidential. We ask these questions so that we are able to provide comprehensive care and counseling.

MENSTRUAL HISTORY

When was the FIRST day of your last menstrual cycle? ______________________________

Was it normal? (Circle) YES NO

Age menstrual cycle began? __________ How often is your cycle? ______________________

Do you currently have any problems with your menstrual cycle currently? (Circle) YES NO

If yes, please describe ____

____

Have you had any problems with your menstrual cycle in the past (Circle) YES NO

If yes, please describe ____

____

GYNECOLOGY HISTORY

When was your last Pap smear? ______________________________________

Have you ever had an abnormal Pap smear? (Circle) YES NO When? ________________

What type of follow up was done? ___________________________________

SEXUAL HISTORY

Sexual Orientation/Gender Identity

_______ Heterosexual _______ Bisexual _______ Homosexual _______ Transgendered _______ Prefer not to state

Are you currently in a sexual relationship currently? YES NO

If NO, when where you last sexually active? ______________________________

If applicable, what contraceptive methods do you or your partner use? ________________

OBSTETRICAL HISTORY

Number of times you have been pregnant? ________________________________

Please indicate number of; Live Birth(s) ________ Miscarriage(s) ________ Still Birth(s) ________ Abortion(s) ________