SURGERY CENTER OF SOUTH CENTRAL KANSAS

Welcome to our office. Please complete this form to the best of your knowledge.

GENERAL INFORMATION: Today's Date ____/____/____

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. Marital Status: ☐ S ☐ M ☐ D ☐ W Gender: ☐ M ☐ F

Patient Name _____
First Middle Last

Social Security Number ____ - ____ - ____ Mother's Maiden Name _____

Home Address _____
Street City State Zip

Do you reside in a skilled nursing facility? ___ Yes ___ No
How do you wish to be addressed? (e.g. – Mr. 1st Name, Nickname) _____

Date of Birth ____/____/____ Home Phone # (___) ____-_____ Cell Phone # (___) ____ - ____

Your Occupation _____ Employer _____ Work # (___) ____ - ____

Spouse's Name _____ Employer _____ Work # (___) ____ - ____

Emergency Contact _____ Relationship _____Phone # (___) ____ - ____

E-mail Address _____

How would you prefer to be contacted? ___Home Phone ___Cell Phone ___Work Phone ___E-mail

If by cell phone: ___ Voice ___ Text

BILLING INFORMATION (if different from patient):

Name of Person Financially Responsible for Account _____

Relationship to Patient _____SSN _____ DOB ___/____/____

Home Phone # (____) _____ - _____ Work # (____) _____ - _____

Address _____
Street City State Zip

MISCELLANEOUS INFORMATION

Do you have an Advance Directive in effect? _____

Would you like information on Living Wills? _____

Is today's visit due to a work related or auto accident? _____

If accident, date of injury, how and where it happened _____

_____

Have you had back surgery? _____ Neck surgery? _____

Have you had a recent MRI or x-ray? _____

Where and when? _____

Family Physician _____

Referred by _____

This is to inform you that in addition to the physician's fee, there will be a facility fee for any procedure or surgery you have at the Surgery Center.

Signature **X** _____ Date _____

MIDWEST PAIN MANAGEMENT

Patient Name: _____ Date of Birth: _____
Referring Physician: _____ Primary Physician: _____

MEDICAL HISTORY

REVIEW OF SYSTEMS: Do you have any problems in the following areas?

CONSTITUTIONAL	No	Yes	?	GENITOURINARY	No	Yes	?	NEUROLOGICAL	No	Yes	?
Fever	☐	☐	☐	Kidney stones	☐	☐	☐	Headaches	☐	☐	☐
Weight loss/gain	☐	☐	☐	Discharge from genitals	☐	☐	☐	Seizures	☐	☐	☐
Cancer	☐	☐	☐	Frequent infections	☐	☐	☐	Dizziness/vertigo	☐	☐	☐
								Stroke	☐	☐	☐
EYES, EARS, NOSE, MOUTH, THROAT				ENDOCRINE							
Dizziness	☐	☐	☐	Diabetes	☐	☐	☐	HEMATOLOGIC / LYMPHATIC			
Sinus Congestion	☐	☐	☐	Thyroid problems	☐	☐	☐	Bleeding problems	☐	☐	☐
Dry throat or mouth	☐	☐	☐	Hepatitis	☐	☐	☐	Anemia	☐	☐	☐
								Jaundice	☐	☐	☐
CARDIOVASCULAR				INTEGUMENTARY				**Do you take blood thinners?**			
Chest Pain	☐	☐	☐	Skin growths/lesions	☐	☐	☐	**(Plavix, Coumadin, Warfarin)**			
Heart attack	☐	☐	☐	Rashes	☐	☐	☐		☐	☐	☐
Heart valve disease	☐	☐	☐								
Pacemaker	☐	☐	☐	GASTROINTESTINAL				ALLERGIC / IMMUNOLOGIC			
Coronary artery disease	☐	☐	☐	Heartburn/gastric reflux	☐	☐	☐	Seasonal allergies	☐	☐	☐
High blood pressure	☐	☐	☐	Gastric ulcers	☐	☐	☐	HIV / AIDS	☐	☐	☐
High cholesterol	☐	☐	☐	Frequent diarrhea	☐	☐	☐	Cancer	☐	☐	☐
				Constipation	☐	☐	☐				
RESPIRATORY								PSYCHIATRIC			
Chronic cough	☐	☐	☐	MUSCULOSKELETAL				Drug addiction	☐	☐	☐
Shortness of breath	☐	☐	☐	Arthritis	☐	☐	☐	Alcohol addiction	☐	☐	☐
Asthma	☐	☐	☐	Osteoporosis	☐	☐	☐	Depression	☐	☐	☐
Emphysema	☐	☐	☐	Joint pain or disease	☐	☐	☐				

SOCIAL HISTORY

Are you employed?	☐ No ☐ Yes	Do you use alcohol?	☐ No ☐ Yes
Do you live alone?	☐ No ☐ Yes	Do you use tobacco products?	☐ No ☐ Yes
Do you use illegal or “street” drugs?	☐ No ☐ Yes	If yes, how much? _____	
Do you drive?	☐ No ☐ Yes	Are you pregnant and/or nursing?	☐ No ☐ Yes

HOSPITALIZATIONS / SURGERIES - List all surgeries, frequent hospitalizations you have had:

_____

_____

_____

ADDITIONAL COMMENTS

_____

_____

The patient meets the ASC admission criteria and the plan to proceed with the procedure.

H&P Update ☐ **No Changes to Condition or Allergy Status**
☐ **See Noted Changes**

Physician Signature _____ **Date** _____