

PATIENT HISTORY – SELF REPORTING

Welcome to our office. Thank you for arriving early to complete this form.

Date:

Name (Last, First, M.I.):	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
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Previous or referring doctor:	Phone number of your doctor:
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PERSONAL HEALTH HISTORY

Describe reason for visit.

When did it start?

Where does it hurt?

Rate severity: (1 mild, 10 severe)

What makes it better / worse?

Previous episodes?

Medical History:	<input type="checkbox"/> None <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Respiratory Disease			
Events and Dates:	<input type="checkbox"/> Blood Clot		<input type="checkbox"/> Pneumonia	
	<input type="checkbox"/> Hepatitis		<input type="checkbox"/> Heart Attack	
	<input type="checkbox"/> Cancer		<input type="checkbox"/> Stroke	

List any other medical problems that other doctors have diagnosed.
Operations **None**

Year	Reason	Hospital
Ever had colonoscopy? <input type="checkbox"/> yes <input type="checkbox"/> no		

Recent hospitalizations **None**

Year	Reason	Hospital
Ever had a blood transfusion? <input type="checkbox"/> yes <input type="checkbox"/> no		

List your prescribed drugs and over-the-counter drugs. We will photocopy your list if available.
 None

Name the Drug	Strength	Frequency Taken
Are you taking any blood thinners? <input type="checkbox"/> yes <input type="checkbox"/> no	Aspirin Plavix Coumadin Warfarin	



ALLERGIES <input type="checkbox"/> None <input type="checkbox"/> Latex			
Name the Drug		Reaction You Had	Date
SOCIAL HISTORY			
Alcohol	Do you drink? <input type="checkbox"/> Yes <input type="checkbox"/> No What kind / amount?	Tobacco	Cigarettes <input type="checkbox"/> Yes <input type="checkbox"/> No _____ pk/day number of years _____ Year quit _____
Work	Type	Drugs	Recreational or street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No List:

FAMILY HEALTH HISTORY

Examples: Breast cancer, heart disease, blood clots, diabetes, bleeding disorders, colon cancer, ovarian cancer

Relationship	AGE	SIGNIFICANT HEALTH PROBLEM	Relationship	AGE	SIGNIFICANT HEALTH PROBLEM

MENTAL HEALTH			PERSONAL SAFETY		
Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have an Advance Directive or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

WOMEN ONLY		MEN ONLY	
Date of last menstruation:		Do you get up to urinate at night? # of times _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any testicle pain or swelling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of pregnancies _____	Number of live births _____	Problems emptying your bladder completely?	<input type="checkbox"/> Yes <input type="checkbox"/> No

REVIEW OF SYSTEMS

Check the positives in boxes that applies to you

<input type="checkbox"/> Constitutional	<input type="checkbox"/> weight changes	<input type="checkbox"/> fever	<input type="checkbox"/> fatigue	<input type="checkbox"/> sweats	
<input type="checkbox"/> Skin	<input type="checkbox"/> rashes	<input type="checkbox"/> itches	<input type="checkbox"/> changing moles	<input type="checkbox"/> lumps	<input type="checkbox"/> skin cancer
<input type="checkbox"/> Eyes/Head	<input type="checkbox"/> headache	<input type="checkbox"/> vision changes	<input type="checkbox"/> double vision	<input type="checkbox"/> dizziness	<input type="checkbox"/> pain
<input type="checkbox"/> ENT	<input type="checkbox"/> hearing changes	<input type="checkbox"/> vertigo	<input type="checkbox"/> sinusitis	<input type="checkbox"/> nose bleed	<input type="checkbox"/> sore throat
<input type="checkbox"/> Respiratory	<input type="checkbox"/> shortness of breath		<input type="checkbox"/> cough	<input type="checkbox"/> chest wall pain	<input type="checkbox"/> sputum
	<input type="checkbox"/> wheezing	<input type="checkbox"/> asthma	<input type="checkbox"/> coughing up blood	<input type="checkbox"/> snoring	<input type="checkbox"/> history of TB
<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> chest pain	<input type="checkbox"/> shortness of breath on exertion	<input type="checkbox"/> extremity swelling	<input type="checkbox"/> heart murmur	
	<input type="checkbox"/> palpitations	<input type="checkbox"/> leg cramps	<input type="checkbox"/> blood clots	<input type="checkbox"/> high blood pressure	
<input type="checkbox"/> Gastrointestinal	<input type="checkbox"/> poor appetite	<input type="checkbox"/> painful swallowing	<input type="checkbox"/> heartburn	<input type="checkbox"/> nausea/vomiting	<input type="checkbox"/> jaundice
	<input type="checkbox"/> abdominal pain	<input type="checkbox"/> blood or tarry looking stools		<input type="checkbox"/> diarrhea	<input type="checkbox"/> constipation
<input type="checkbox"/> Genitourinary	<input type="checkbox"/> pain on urination	<input type="checkbox"/> bloody urine	<input type="checkbox"/> frequent urination	<input type="checkbox"/> urgency	<input type="checkbox"/> hesitancy
	<input type="checkbox"/> incontinence	<input type="checkbox"/> vaginal or urethral discharge	<input type="checkbox"/> testicular pain or swelling		
<input type="checkbox"/> Musculo-skeletal	<input type="checkbox"/> joint or back pain	<input type="checkbox"/> swelling	<input type="checkbox"/> stiffness	<input type="checkbox"/> deformity	<input type="checkbox"/> muscle aches
					<input type="checkbox"/> weakness
<input type="checkbox"/> Neurological	<input type="checkbox"/> dizziness	<input type="checkbox"/> passing out	<input type="checkbox"/> strokes	<input type="checkbox"/> muscle weakness or paralysis	
	<input type="checkbox"/> memory changes	<input type="checkbox"/> speech disturbances		<input type="checkbox"/> seizures	
<input type="checkbox"/> Psychiatric	<input type="checkbox"/> depression	<input type="checkbox"/> sleep disturbance	<input type="checkbox"/> suicidal ideation	<input type="checkbox"/> anxiety	<input type="checkbox"/> eating disorder
	<input type="checkbox"/> delusions	<input type="checkbox"/> behavioral changes			<input type="checkbox"/> hallucinations
<input type="checkbox"/> Hematologic	<input type="checkbox"/> anemia	<input type="checkbox"/> easy bruising	<input type="checkbox"/> heavy bleeding		
<input type="checkbox"/> Endocrine	<input type="checkbox"/> heat intolerances	<input type="checkbox"/> cold intolerance	<input type="checkbox"/> frequent urination	<input type="checkbox"/> excessive thirst	
<input type="checkbox"/> Immunologic	<input type="checkbox"/> seasonal allergy	<input type="checkbox"/> lupus	<input type="checkbox"/> rheumatoid arthritis		
<input type="checkbox"/> Functional Status	difficulties with...	<input type="checkbox"/> bathing	<input type="checkbox"/> ambulating	<input type="checkbox"/> dressing	<input type="checkbox"/> cooking

All other review of systems negative

Physician Initial _____



PATIENT FULL NAME: _____ Sex: male female

Social Security Number: _____ - _____ - _____ Date of Birth: _____ Age: _____

Street Address: _____ PO Box: _____

City / State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Preferred Method of Contact: Home Cell Work Email address: _____

Special Contact Instructions: _____

Patient Status: Married Single Divorced Widowed Employed Retired Student: FT PT

Spouse's Name: _____ Phone: _____

Emergency notification: _____ Phone: _____

Patient's Employer: _____

Employer Address : _____

Current Medical Condition: Work Related _____ Auto Accident _____ (state _____) Workers Comp _____

Date of Occurrence: _____

REFERRING PHYSICIAN: _____ Phone: _____

PRIMARY CARE PHYSICIAN: _____ Phone: _____

OTHER SPECIALTY PROVIDERS: _____

PHARMACY NAME & PHONE: _____

Has Dr. Jurani ever treated someone you know? _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ HMO/PPO Copay:\$ _____ % _____

Subscriber Name: _____ DOB: _____

Subscriber's Employer: _____ Effective Date: _____

SECONDARY INSURANCE: _____ HMO / PPO

Subscriber Name: _____ DOB: _____

Subscriber's Employer: _____ Effective Date: _____

Patient Signature: _____ Date: _____

PATIENT FINANCIAL POLICY

Thank you for choosing Prairie Surgical Care. Once you have read our financial policy, if you have any questions regarding our fees or patient responsibilities, please feel free to discuss them with any of our staff. We encourage our patients to contact their insurance company to verify Prairie Surgical Care is a participating provider and to familiarize themselves with their insurance plan benefits, prior to their appointment. *If you are unable to keep your appointment please let us know so we may offer your time to another patient in need.* When you first check in, we will ask for your insurance card(s) and a photo ID. These cards will be copied and scanned into our system. Please inform us of any changes in your information: insurance, mailing address, phone numbers, pharmacy information etc.

REFERRALS: Some insurance plans require a referral from your Primary Care Physician. It is the patient's responsibility to obtain any and all referrals prior to your appointment. We will reschedule any appointment if the referral is not secured.

COPAYMENTS: Please be prepared to pay your co-pay at the time of service. We will reschedule appointments if you are unable to pay the co-pay, unless prior arrangements have been made. There is no co-pay for most post operative visits.

DEDUCTIBLES: When an office visit copayment is not designated on your insurance card, an estimate of patient responsibility will be obtained from your insurance company when possible. Patients will be responsible to pay that estimated cost at the time of service.

PATIENT BALANCES: Coinsurance and deductible balances for office visits and procedures are due upon receipt of your statement. If your responsibility is more than you are able to pay, we are willing to set up a convenient 6 month payment plan. We will be happy to answer any questions you may have regarding these balances. Contact us at 913-432-4355.

SELF PAY: Patients without insurance or evidence of insurance will be considered self pay. The new patient fee is \$100.00 and established patients fee is \$50.00. This fee is required at time of service. There will be an additional fee if an in-office procedure is performed.

FEES: FMLA/DISABILITY FORMS: Our fee is \$15.00. Forms are completed after your post-operative visit to ensure accurate return to work dates. This eliminates incurring additional fees when forms are corrected or filled out multiple times. We are happy to provide a Work Release free of charge. There is a \$25.00 charge for any returned checks for insufficient funds.

WE ACCEPT: Checks, Cash, Credit Cards, Debit Cards and money orders (Visa, MC & Discover)

RESPONSIBLE PARTY SIGNATURE: _____ **DATE** _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PATIENTNAME: _____ DOB: _____

I hereby give permission for the physician and office staff of PRAIRIE SURGICAL CARE to discuss my **MEDICAL CONDITION AND CARE** with the following persons (i.e. family members, friends, employers, etc.):

Name	Relationship	Phone

I hereby give my permission for the office staff at PRAIRIE SURGICAL CARE to discuss my **ACCOUNT INFORMATION** with the following person:

Name	Relationship	Phone

I understand that if I want to request **COPIES OF MY MEDICAL RECORDS**, that my request will need to be made either in person or in writing, including my signature.

SIGNED: _____ DATE: _____

Form of Written Acknowledgement of Receipt of
Prairie Surgical Care's Notice of Patient Privacy Practices

By signing below, I acknowledge receipt of Prairie Surgical Care's Notice of Patient Privacy Practices.

Signature of Patient or Legal Representative: _____ Date: _____

Printed Name of Patient: _____

Form of Written Acknowledgement and Understanding of
Patients Consent to-treat and Assignment of Benefits

While I am here I permit the employees, Dr Jurani, and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand Dr Jurani will explain to me the nature of my condition and his recommended treatment and any associated risk involved. I also understand that he will explain to me other ways this condition could be treated. I further understand that this care may include tests, examinations, medical and/or surgical treatment, No guarantees have been made to me about the outcome of this care.

I hereby authorize Prairie Surgical Care to release all information necessary to secure payment. I assign all benefits for unpaid service to which I am entitled to Prairie Surgical Care. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I request that payment of authorized commercial insurance, Medicare and Medigap benefits be made on my behalf to Prairie Surgical Care. I authorize any holder of medical information about me to release to Medicare (HCFA) and its agents and/or Medigap any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient or Legal Representative: _____ Date: _____