Prairie Surgical Care

Carlo Jurani, M.D. Phone 913-432-4355 Fax 913-432-5994

PATIENT HISTORY – SELF REPORTING

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

			Date:
Name *(Last, First, M.I.):*		☐ M ☐ F	DOB:
Previous or referring doctor: (we will send them a letter about your visit today)		Phone number of your doctor:	

PERSONAL HEALTH HISTORY

Describe your symptoms.

When did it start?

Where does it hurt?

What makes it better? What makes it worse?

Rate severity: (1 mild, 10 severe)

Previous episodes? Any testing done?

Medical History:	☐ **None** ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Respiratory Disease			
Events and Dates:	☐ Blood Clot		☐ Pneumonia	
	☐ Hepatitis		☐ Heart Attack	
	☐ Cancer		☐ Stroke	

List any other medical problems that other doctors have diagnosed.

Operations ☐ **None**

Year	List operation and reason for surgery.	Hospital
	Ever had colonoscopy? ☐ yes ☐ no Please estimate when _____	

Recent hospitalizations ☐ **None**

Year	Reason	Hospital
	Ever had a blood transfusion? ☐ yes ☐ 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? ☐ yes ☐ no	Aspirin Plavix Coumadin Warfarin	

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ALLERGIES ☐ **None** ☐ **Latex**

Name the Drug	Reaction You Had	Date

SOCIAL HISTORY

Alcohol	Do you drink? ☐ Yes ☐ No What kind / amount?	**Tobacco Ever smoked?**	Cigarettes ☐ Yes ☐ No _____ packs/day number of years _____ Interested in quitting?_____
Work	Type	**Drugs**	Recreational or street drugs? ☐ Yes ☐ 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

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems eating or your appetite?	☐ Yes	☐ No

PERSONAL SAFETY

Do you live alone?	☐ Yes	☐ No
Do you have frequent falls?	☐ Yes	☐ No
Do you have vision or hearing loss?	☐ Yes	☐ No
Do you have an Advance Directive or Living Will?	☐ Yes	☐ No

REVIEW OF SYSTEMS

Date of last menstruation:	Do you get up to urinate at night? # of times _____	☐ Yes	☐ No
How many bowel movements per day?_____	Any problems with control of urination?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____	Problems emptying your bladder completely?	☐ Yes	☐ No

Check the positives in boxes that applies to you

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

☐ All other review of systems negative

Name_____ Date of Birth_____

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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:_____

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PATIENT FINANCIAL POLICY

Please ask if you have any questions about our fees, or your financial responsibility. We will ask to see your insurance card on your first visit and will scan your card into our system as needed to keep our information current. We may ask for this information on a regular basis in order to ensure that no change in benefits or carrier has occurred. Please notify us if your insurance carrier or policy has changed.

FMLA / DISABILITY FORMS: We do not want you to worry about these forms. We are happy to provide a Work Release Form, free of charge, when you return for you post operative clinic visit. If you have FMLA forms, they will be completed after your first post operative clinic visit to ensure your estimated return to work date is as accurate as possible. There is a $15 per form fee and for each time the paperwork is required. If forms are required prior to your post operative visit the fee is $30.00.

COPAYMENTS: Your insurance *requires* that we collect your designated co-pay at the time of service. Please be prepared to pay the co-pay at each visit. There is no co-pay for your post operative visit.

NON-PARTICIPATING INSURANCE PLANS: As a service to our patients, we will bill as a non-assigned claim. Any outstanding balances are the responsibility of the patient.

REFERRALS: If your insurance plan requires a referral from your primary care physician it is your responsibility to obtain it prior to your appointment and to have it with you at the time of the appointment.

MEDICARE: We will submit to Medicare for the Medicare allowed amount. The patient will be responsible for the deductible and co-insurance, which can be billed to a secondary insurance if you have one.

RETURNED CHECK FEES: Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a $25.00 fee per check returned.

SELF-PAY: Self-pay accounts shall exist if a patient has no insurance coverage or no evidence of insurance coverage. For new patients, a payment of $100.00 is expected on the day of your appointment before being seen by the health care provider. If you are unable to pay the $100 please contact us prior to your appointment. A discount off regular fees is offered for payment made at time of service.

NO SHOWS: We understand that you may not always be able to keep your appointment. Please call to inform us that you will not be here at least 3 hours before your scheduled appointment otherwise we may charge a $25 no-show fee.

WE ACCEPT: Cash, Mastercard, Visa, and Checks. You may also make credit card payments by phone.

RESPONSIBLE PARTY SIGNATURE:_____DATE:_____

Patient Name (if different from Responsible Party): _____

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME:_____ DOB:_____

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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 designated here(i.e. family members, friends, employers, etc.):

NAME	RELATIONSHIP	PHONE

****

I hereby give my permission for the physician and 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:_____

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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:_____