WORKERS COMPENSATION INFORMATION

PATIENT INFORMATION

First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City, State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_ Sex\_\_\_\_\_\_\_\_\_\_\_

Race: as American Indian or Hispanic Asian Black or African American Caucasian Other\_\_ \_\_\_\_\_\_\_\_\_

Ethnic: Hispanic or Latino Not Hispanic or Latino Marital Status:\_\_\_\_\_\_\_ Social Security No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Language: English Spanish Indian Japanese Chinese Polish Other\_\_\_\_\_ \_\_\_\_\_\_

Emergency Contact First Name:\_\_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_ Last Name:\_\_\_ \_\_ \_\_\_\_\_\_\_\_\_\_ Phone No. \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Emergency Contact Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMPLOYER**

Employer’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employers Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Employers Telephone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Injury verified by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ \_\_\_\_\_\_

Contact Person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Injury Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

CARRIER INFORMATION

Workers Compensation Carrier\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Carrier Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Carrier Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adjuster\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claim Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INJURY INFORMATION

Have you seen another physician for this condition? Yes No

Doctor’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were X-Rays taken? Yes No Other test? Yes No

If yes, please list test and by whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any previous Workers Compensation Injuries, if yes, please explain

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Alan Chen Surgical Associates, P.C. to release any medical information for insurance purposes and assign the above workmen’s compensation benefits to Alan Chen Surgical Associates for services rendered. I also understand that I am directly responsible for services, which are NOT paid by insurance and these payments are due within 60 days of the date the payer receives substantially all the information needed to adjudicate a bill. Unpaid bills accrue interest at 1% per month. Should the account be referred for collection, I shall pay reasonable costs of collection including legal fees.

Patients Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I hereby authorize Alan Chen Surgical Associates, P.C and/or Aesthetica Chicago Associates, P.C. to release any medical information for insurance purposes and assign the above insurance or workmen’s compensation benefits to Alan Chen Surgical Associates, P.C and/or Aesthetica Chicago Associates services rendered. I also understand that I am directly responsible for services, which are NOT paid by insurance and these payments are due within 60 days of the date the payer receives substantially all the information needed to adjudicate a bill. Unpaid bills accrue 15% per month. Should the account be referred for collection, I shall pay reasonable costs of collection including legal fees.**

* **If a deductible for the year has not been met patient will have to pay $75 up front for an office visit.**
* **Once payment has been received from any insurance company, any patient responsibility remaining will be payable by the patient upon their next office visit or receipt of statement, whichever comes first**
* **If a patient is having an office procedure they will be responsible to pay the deductible not met for the year calculated by the office prior to the procedure.**
* **ALL patients that need a REFERRAL for any visit or office procedure is RESPONSIBLE for bringing it in or making sure our office has been faxed a copy prior to the scheduled appointment.**
* **Co-payments and other self-pay amounts are due prior to being seen in the office**
* **A fee of $25.00 may be applied to patient account for any returned checks. The RETURNED CHECK FEE is only payable in cash or by money order.**
* **Any scheduled office appointment needs to be cancelled 24 hours prior to scheduled time or a $50 missed appointment fee will be billed out to the patient.**
* **A $15.00 fee will be collected for any documents needed to be completed by our staff (FMLA, Disability, Aflac, etc.)**
* **If this visit is work related you must inform our receptionist immediately. You are required to get all insurance information from your employer.**

**Patient or Representative’s Printed Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient or Representative’s Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Acknowledgement of HIPAA Privacy and Consent Form**

Alan Chen Surgical Associates, P.C. (referred to below as “This Practice”). Notice of Privacy practice provides information about you. The notice contains a Patient Rights section describing your rights under law. You have the right to review our Notice before signing consent. The terms of our Notice may change. If we change our Notice, you may obtain a request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care if we do, we shall honor that agreement. By signing this form you consent to our use and disclosure of protected health information about your treatment, payment and health care operations. You have the right to revoke this consent, in writing, assigned by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior consents. This practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I have read and understand the *NOTICE OF PRIVACY PRACTICES* containing a more complete description of the use and disclosure of my health information, or I was offered a copy in which I did not wish to review.

I understand that:

Protected health information may be disclosed or used for treatment, payment, or health care operations. This Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice. This Practice reserves the right to restrict the uses of their information but This Practice does not have to agree to those restrictions. The patient may revoke this Consent in writing at any time and all future disclosures will then cease. This Practice may condition receipt of treatment upon the execution of this Consent.

I give permission to This Practice to release my medical information regarding, treatment, billing, and the status of my health and medical conditions to my family member or other designated person(s) listed below. This pertains to phone calls or any office interactions regarding you. **Be sure to include your Primary Care Doctor should we need to forward information. List your significant family members name if they share your healthcare. Anyone not listed on the form cannot receive information about you.**

🡪\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🡪\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🡪\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request This Practice to keep communications regarding my protected health information confidential. To accomplish this please adhere to the following specific requests in regards to the confidential communication of my protected health information:

You can contact me by phone (circle which apply): **HOME WORK CELL**

You may leave message on (circle which apply): **HOME WORK CELL**

You may leave a verbal message with the following persons:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient History Form** MA/PA/Student Initials:\_\_\_\_\_\_\_\_\_\_

Please indicate whether or not you have experienced any of the following.

**PAST & PRESENT MEDICAL SURGICAL HISTORY**

No Yes Comments No Yes Comments

HIV   High Blood Pressure  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis (A,B,C)   When? Breast Cancer  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tuberculosis   Treated? Cancer  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bleeding Disorders   Abdominal Bleeding  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blood Thinners   Gastrointestinal Disorder  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pacemaker   Kidney Stones  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes   Hives  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous MI   Skin Cancer  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Malignant Hyperthermia   Skin Disease  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of Smoking   Present: Ulcers  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Visual Problems   Rheumatoid Arthritis  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid Disorders  Hyper Or Hypo? Osteoporosis  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Migraines   Osteoarthritis  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma   Stroke  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lung Disease   Depression  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chest Pain/Tightness   Anxiety  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Murmur   Radiation  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Disease   Weight Change  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Cholesterol   Cold Sores  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexually Transmitted Disease  Other  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE LIST ALL THAT APPLY:**

Fatigue   Shortness of breath  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weakness   Headaches  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Loss of appetite   Vomiting  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Skin Rash   Diarrhea  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dry Skin   Constipation  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sore Throat   Breast Tenderness  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nose Bleeds   Breast Discharge  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Difficulty Swallowing   Difficulty Urinating  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chest Pain   Blood in Urine  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cough   Frequent Urination  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Muscle Weakness   Dizziness  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Joint Pain   Numbness  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Muscle Spasms   Tingling  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blurry Vision   Bruising  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Glasses or Contacts   Abnormal Bleeding  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nausea   Other  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **FAMILY HISTORY**

Are you adopted?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have your grandparents, parents, brothers or sisters ever had: Malignant Hyperthermia  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sickle Cell Disease  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stroke/ Blood Clots  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Attack  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High Cholesterol  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Blood Pressure  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Others\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE LIST ANY ALLERGIES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Conditions/ Diagnosis:** (examples: asthma, high blood pressure, bleeding tendencies, shortness of breath, heart attack, chest pain/ angina, heart murmur, hepatitis/ jaundice, diabetes, thyroid problems, kidney/ bladder issues, epilepsy/convulsions, HIV or Exposure)

**Reason for visit**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NO CURRENT MEDICAL CONDITIONS / DIAGNOSIS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medical condition / diagnosis** | **Date of initial diagnosis** | **Current Status of this condition** | **Completed**  **by** | **Leave blank**  **REMARK** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**NO PAST SURGERIES OR PROCEDURES**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Surgery / Procedure** | **Date of Surgery** | **Facility or Location** | **Performed by:**  **(Doctors Name)** | **Problems with Anesthesia?** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**NOT CURRENTLY TAKING ANY MEDICATIONS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Name**  **(Including OTC/Herbal/Vitamins)** | **Dose**  **(mg/mcg/ml)** | **Route**  **(By mouth, injection, inhaled, etc. )** | **How Often (daily, twice daily, three times daily, etc.)** | **Prescribed by:**  **(Doctors Name)** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: Today’s Date