



**PATIENT**

All new patients				Complete this section if patient is not the guarantor					
Last Name		First Name		Last Name		First Name		Relationship to Patient Spouse Parent Other	
Address				Address					
City		ST	Zip	City		ST	Zip		
Primary Phone		Phone 2	Phone 3	Primary Phone		Phone 2	Phone 3		
Email Address				Email Address					
Social Security Number	Date of Birth (MM-DD-YY)	Age	Sex M F	Social Security Number	Date of Birth (MM-DD-YY)	Age	Sex M F		
Emergency Contact		Emergency Phone		Emergency Contact		Emergency Phone			
Marital Status S M W Other		Maiden Name		Marital Status S M W Other		Maiden Name			
Patient Employment/Student Status <input type="checkbox"/> Employed <input type="checkbox"/> Student <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time				Guarantor Employment/Student Status <input type="checkbox"/> Employed <input type="checkbox"/> Student <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time					
Occupation				Occupation					
Employer or School		Phone Number		Employer or School		Phone Number			
Please list any known allergies									

**REFERRING DOCTOR**

Last Name		First Name		Referring Doctor's Phone Number		Primary Care Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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**INSURANCE INFORMATION**

Primary Insurance		Secondary Insurance		Other Insurance	
Insurance Company	Phone	Insurance Company	Phone	Insurance Company	Phone
Subscriber's Name		Subscriber's Name		Subscriber's Name	
Subscriber's Birthdate		Subscriber's Birthdate		Subscriber's Birthdate	
Social Security Number		Social Security Number		Social Security Number	
Insured ID (Policy No.)	Group/FECA#	Insured ID (Policy No.)	Group/FECA#	Insured ID (Policy No.)	Group/FECA#

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND BENEFITS:**

I/We hereby authorize Utah County Surgical Associates, P.C. to release any medical information that may be necessary for either medical care or in processing insurance for financial benefit. I/We will be responsible for payment for the services rendered, and furthermore agree to pay attorney fees, court costs, collection and filing fees, including charges or commission up to fifty percent that may be assessed to us by any collection agency retained to pursue this matter. I/We further agree to pay interest at the rate of 1.5% per month (18% per year). I/We understand and agree that I/we are financially responsible for all deductible amounts, Co-insurance, non-covered services or services deemed as "non-medically necessary" by my third party insurance carrier.

Patient/Guarantor Signature		Date	Spouse Signature		Date
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**MEDICARE PATIENT AGREEMENT:**

I request that payment of authorized Medicare benefits be made on my behalf to Utah County Surgical Associates for any service rendered to me by such provider. This authorization will remain in effect until I choose to revoke it in writing.

Signature \_\_\_\_\_ Date \_\_\_\_\_



(CONFIDENTIAL)

Please fill out this health information form as completely as possible.

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Today's Date \_\_\_\_\_

MAIN REASON YOU ARE HERE \_\_\_\_\_

SYMPTOMS YOU ARE HAVING \_\_\_\_\_

\_\_\_\_\_

**MEDICAL ILLNESS**

List all illnesses that you have or have had.

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

**SURGERIES**

List each surgery with the year it was done (include biopsies and tonsils).

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

**MEDICATIONS**

List all that you are taking (including vitamins and BCP).

Drug Name	Dosage	Prescribed by
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List drugs or medications to which you are allergic and the reaction \_\_\_\_\_

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

Preferred Pharmacy \_\_\_\_\_

(SEE NEXT PAGE)



	Living		Age or age at time of death	Cause of death or current health problems
Father	YES	NO	_____	_____
Mother	YES	NO	_____	_____

List any health problems in brothers or sisters \_\_\_\_\_  
 \_\_\_\_\_

Check any of these illnesses that have occurred in your family and list who:

- Gallbladder \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Strokes \_\_\_\_\_
- Heart Disease \_\_\_\_\_
- Blood Pressure \_\_\_\_\_
- Breast Cancer \_\_\_\_\_
- Other Cancer-*list type* \_\_\_\_\_
- Problems with Anesthesia-*what problems* \_\_\_\_\_

Marital Status:      Single      Married      Divorced      Widowed

Occupation \_\_\_\_\_ Other \_\_\_\_\_

Do you use tobacco? \_\_\_\_\_ How Much? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ How Much? \_\_\_\_\_

Do you use illicit drugs? \_\_\_\_\_ Which ones? \_\_\_\_\_

Do you follow a special diet? \_\_\_\_\_ What Type? \_\_\_\_\_



PATIENT NAME: \_\_\_\_\_

In each category, check all symptoms that apply.

CONSTITUTIONAL: ~~None~~ None Fever Chills Weight loss Weight gain Fatigue  
~~None~~ Body aches Night sweats

HENT: None Sore throat Nasal congestion Headaches

BREASTS: None Lumps Nipple Discharge

CARDIOVASCULAR: None Chest Pain Heart murmur Irregular heart rate Swelling in legs  
Trouble breathing with exertion Pain in legs while walking

RESPIRATORY: None Wheezing Cough Hoarseness Sleep apnea Blood in sputum  
Problems with anesthesia Shortness of breath Abnormal sputum production

GASTROINTESTINAL: None Heartburn Nausea Vomiting Bloating Loss of appetite  
Difficulty swallowing Diarrhea Constipation Jaundice Blood in stool Abdominal pain  
Black, tarry stools Hemorrhoids Pain with swallowing Mucous in stool Narrow stools  
Early fullness with eating Feeling of incomplete bowel emptying

GENITOURINARY: None Painful urination Urinating at night Blood in urine  
Change in urine color Difficulty with urination

INTEGUMENT: None Rash Itching New skin lesions/moles Change in skin lesions/moles

NEUROLOGIC: None Numbness Tingling Seizures

MUSCULOSKELETAL: None Bone pain Back pain Joint pain Muscle pain Muscular weakness

ENDOCRINE: None Cold intolerance Heat intolerance

PSYCHIATRIC: None Depression Anxiety

HEME-LYMPH: None Easy bleeding Easy bruising Enlarged lymph nodes  
Painful lymph nodes