M. SHANE DAWSON MD
GENERAL / LAPAROSCOPIC / ROBOTIC SURGERY

DEMOGRAPHIC INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ WHAT IS YOUR GENDER: _____

WHAT SEX WAS RECORDED AT BIRTH? _____ PREFERRED PRONOUNS: _____

ADDRESS: _____APT #: _____

CITY: _____ STATE: _____ ZIP: _____

PREFERRED PHONE NUMBER: _____ HOME or CELL

ALTERNATE PHONE NUMBER: _____

EMAIL: _____

RELATIONSHIP STATUS: _____ SINGLE _____ MARRIED _____ PARTNER _____ DIVORCED _____ WIDOWED

PREGNANT (CHECK IF APPLICABLE) _____ NURSING (CHECK IF APPLICABLE) _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? _____

EMERGENCY CONTACT INFORMATION

CONTACT FIRST AND LAST NAME: _____

CONTACT PHONE: _____ RELATIONSHIP: _____

CONTACT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

By signing below, I attest that the information provided above is true and accurate

SIGNATURE OF INSURED / GUARDIAN: _____ DATE: _____

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PRIMARY INSURANCE

INSURANCE COMPANY: _____

MEMBER ID #: _____ GROUP #: _____

PROVIDE THE INFO BELOW IF YOU ARE COVERED UNDER SOMEONE ELSE'S POLICY (spouse, parent, etc.)

INSURED'S NAME: _____

INSURED'S DOB: _____RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

CITY: _____ STATE: _____ZIP: _____ PHONE: _____

SECONDARY INSURANCE

INSURANCE COMPANY: _____

MEMBER ID #: _____ GROUP #: _____

INSURED FIRST NAME: _____ LAST NAME: _____

SOCIAL SECURITY #: _____DOB: _____RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

CITY: _____ STATE: _____ZIP: _____ PHONE: _____

EMPLOYMENT STATUS

____ EMPLOYED ____ UNEMPLOYED ____ RETIRED _____ FULL TIME STUDENT

OCCUPATION: _____ BUSINESS NAME: _____

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NAME: _____ DOB: _____

HEIGHT: _____ WEIGHT: _____

MEDICAL HISTORY:

_____

_____

PAST SURGICAL HISTORY:

_____

_____

ANY HISTORY OF ANESTHESIA COMPLICATIONS (INCLUDING IN YOUR FAMILY)?

_____

_____

DO YOU HAVE A HISTORY OF ANY BLEEDING DISORDERS? YES NO

IF YES, PLEASE INDICATE: _____

DO YOU CURRENTLY SMOKE? YES NO

HAVE YOU EVER USED: _____ CIGARETTES OR E-CIGARETTES _____ OTHER FORMS OF TOBACCO

DO YOU CURRENTLY DRINK ALCOHOL? YES NO

IF YES, PLEASE INDICATE HOW MANY DRINKS PER DAY: _____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? YES NO

IF YES, PLEASE INDICATE: _____

162 EAST 78TH STREET, FLOOR 1, NEW YORK, NY 10075 TELEPHONE: (212) 744-1100 FAX: 1-877-732-3203

CURRENT MEDICATIONS: (BE SURE TO INCLUDE ANY ANTICOAGULANT OR ANTIPLATELET MEDICATIONS)

_____ _____

_____ _____

_____ _____

(IF YOU TAKE NUMEROUS MEDICATIONS, PLEASE ATTACH A FULL LIST OF NAMES WITH DOSAGES TO THESE FORMS)

DO YOU HAVE A PACEMAKER OR ANY CARDIAC STENTS/DEVICES?	YES	NO
ARE YOU ALLERGIC TO LATEX?	YES	NO
DO YOU HAVE A HISTORY OF SLEEP APNEA?	YES	NO
DO YOU HAVE A HISTORY OF HEART DISEASE?	YES	NO

RECENT X-RAY AND/OR LABORATORY STUDIES:

_____

_____

REFERRING PHYSICIAN: _____

ADDRESS: _____

PHONE: _____FAX: _____

PRIMARY CARE PHYSICIAN: _____

ADDRESS: _____

PHONE: _____FAX: _____

PHARMACY: _____

ADDRESS: _____

PHONE: _____FAX: _____

_____ _____

SIGNATURE/RELATIONSHIP TO PATIENT REVIEWED BY:

M. SHANE DAWSON MD
GENERAL / LAPAROSCOPIC / ROBOTIC SURGERY

MEMBER AUTHORIZATION FOR A DESIGNATED REPRESENTATIVE TO APPEAL A DETERMINATION

DATE: _____

MEMBER NAME: _____

MEMBER INSURANCE ID #: _____

I hereby authorize M. SHANE DAWSON, MD, PLLC to appeal the determination of _____ on my behalf, as my Designated
(Insurance Company Name)
Representative, and, as part of the appeal, I hereby authorize _____ in its decision letter and in connection
(Insurance Company Name)
with the processing of my appeal, to communicate with my Designated Representative concerning the following:

All medical and financial information contained in my insurance file, including but not limited to my treatment and hospital confinement in connection with the determination which is being appealed.

I understand this information is privileged and confidential and will only be released as specified in this Authorization. This authorization is valid for a period of one year

_____
Signature of Member or Legal Guardian/Representative

_____
Printed Name

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AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATION

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by M Shane Dawson MD PLLC in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I AGREE AND CONSENT TO RELEASING MY HEALTH INFORMATION TO ME IN THE FOLOWING MANNERS:

VIA EMAIL	**PLEASE INITIAL**
_____ OK TO EMAIL TO THE ADDRESS LISTED ON PAGE 1	_____
VIA POSTAL MAIL	
_____ OK TO MAIL TO HOME ADDRESS	_____
VIA HOME PHONE OR CELL PHONE	
_____ OK TO LEAVE DETAILED MESSAGE	_____
_____ LEAVE CALL BACK NUMBER ONLY	_____

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IN-OFFICE CONSULTATION FEE POLICY
FOR NEW PATIENTS WITH OON BENEFITS

The total fee for the office consultation is $515. We collect $250 towards the consultation fee at the time of your visit. Our office will then submit a bill to your insurance in the amount of $515 for payment. Depending on the details of your policy, the amount that your insurance pays toward the claim will vary. In some instances, the insurance will pay this claim in full. Should this occur, our office will be happy to reimburse you the $250 paid at the visit.

Please be aware that certain OON insurance plans issue claim payment checks directly to their members (you). Should you receive a check from your insurance company to cover the cost of our professional services, it is your obligation to then make payment directly to our practice.

_____ _____

PATIENT SIGNATURE DATE

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