General Surgical Care, P.C.

Mark E. Schadt, M.D. Richard W. Conron Jr, D.O.

Patient : _____ **Birthdate:** _____ **Age:** ___ **Gender: M F**

Address: _____

Primary Phone: _____ **Secondary Phone**_____ **Work Phone:** _____

Preferred Contact Number: _____**Occupation:** _____

Email Address: _____ □ Decline to provide email

SS# _____-_____-_____ **Spouse/Partners Name:** _____

Referred By: _____ **Family Doctor :** _____

Please list any specialists you see: _____

Prescription Medications: _____

_____

_____

Over the Counter/Supplements: _____

Latex Allergy: □ No □ Yes **Penicillin Allergy:** □ No □ Yes Reaction _____

Other Allergies: _____

Height:_____ **Weight:**_____ **Daily Aspirin?** □ No □ Yes □ 81mg □ 325mg

Past Medical History: Please check any conditions you have had

□ Diabetes □ Liver Conditions □ GERD/Ulcer □ Heart Disease □ Colon Disorders

□ Kidney Disease □ Sleep Apnea □ Lung Disease □ Seizures □ High Blood Pressure

□ CHF □ Stroke □ Thyroid Disorder □ Bleeding Tendency □ Anemia

Have you ever taken blood thinners? (Coumadin, Plavix, Xarelto,Eliquis etc.) _____

Other significant medical history: _____

_____

Surgical History: _____

_____

Alcohol Use: □ Never □ Occasionally □ Socially □ Daily **Substance Abuse:** _____

Smoking: □ Current Number per day _____ □ Never □ Former When did you quit? _____

Family History: Please indicate any relatives with the following conditions

	Mother	Father	Siblings	Other
Heart Disease				
High Blood Pressure				
Stroke				
Cancer (type)				
Diabetes				
Thyroid Disease				
Bleeding disorder				
Seizures				
Other				

Pharmacy and location: _____

Authorization: I hereby authorize the physician indicated above to furnish information to insurance carriers concerning this illness/injury, and I hereby irrevocably assign to the doctor all payments for medical services rendered.I understand that I am financially responsible for all charges whether covered by my insurance or not. General Surgical Care will access your Pharmacy records via electronic records program. This will allow for accurate medication history in your medical record. Please address any complaints or criticisms in person or via telephone with our office.

HIPPA Notice: By signing the below, I agree that I have reviewed the posted notice of privacy practices for protected health information, and I understand my rights as a patient of this practice. ***Unless otherwise specified, I authorize General Surgical Care to release my medical information to my spouse, care givers, or physician's office. I authorize other caregivers/Physician offices to release information needed for my treatment to General Surgical Care upon request.(letters, test results etc) ***

Patient Signature: _____ **Date:** _____

If patient is a minor please provide relationship: _____

Emergency Contact: _____ **Phone Number:** _____

Primary Language: _____ Race: Asian Native American Black Hispanic Caucasian

Are you LEFT or RIGHT handed? Marital Status: _____

Prefer not to answer □