GENERAL SURGERY ASSOCIATES

Associated Surgical Groups

New Patient Registration and Questionnaire (Page 1)

Referring Physician: Primary Physician:

Patient Information			
Name:			Sex: ☐ M ☐ F ☐ T
Birth Date: Age:	Marital Status:		Preferred Method of Contact: ☐ Email ☐ Mail ☐ Text ☐ Phone Preferred Phone Number: ☐ Home ☐ Cell
Social Security Number:			
Email Address:			
Address:		Apt #:	
City, State:		Zip Code:	
Home Phone #:		Cell Phone #:	

Patient Employer Information		
Employer:	Phone #:	Ext #:
Address:	Suite #:	
City, State:	Zip Code:	

Guarantor Information (Insurance Policy Holder)	**Emergency Contact Information**
Name:	Name:
Relationship:	Relationship:
Employer:	Address:
Address:	City, State, Zip:
City, State, Zip:	Phone #:
Phone #:	

Insurance Information		
Primary Insurance:	Subscriber Name:	DOB:
	Insurance ID #:	
Secondary Insurance:	Subscriber Name:	DOB:
	Insurance ID #:	

Demographics	
Race:	Ethnicity:
Preferred language:	Do you need a translator?: ☐ Y ☐ N
Are you hearing impaired?: ☐ Y ☐ N	Do you have an Advance Directive?: ☐ Y ☐ N ☐ DNR ☐ Organ Donor ☐ _____

The above information is correct & accurate to the best of my knowledge.

_____ _____

Signature of Patient/Parent/and or Guarantor *Date*

Name: _____

GENERAL SURGERY ASSOCIATES

Associated Surgical Groups

New Patient Registration and Questionnaire (Page 2)

1. Pharmacy Information

Please provide the name and location of your preferred pharmacy:

Name: _____ Phone #: _____

Cross Streets: _____

2. Medications

Are you currently taking any medications? ☐ Y ☐ N If yes, please list below:

Prescribed Drugs, Over the Counters, Vitamins	Currently On?		Dose	Reason for Taking
	Yes	No		

Are you currently taking any Blood Thinners? ☐ Y ☐ N If yes, please list above:

For additional space, please use addendum on page 4

3. Allergies

Do you have any drug allergies? ☐ Y ☐ N If yes, please list below:

Drug	Reaction

For additional space, please use addendum on page 4

4. Surgical History

Have you ever had surgery? ☐ Y ☐ N (If yes, please specify below)

Procedure	Date	Location	Surgeon

For additional space, please use addendum on page 4

5. Social History

A. What is your current smoking status? ☐ Never ☐ Past Smoker ☐ Current Smoker
How many packs per day? _____ How many years of smoking history? _____

B. Do you drink alcoholic beverages? ☐ Y ☐ N If yes, how many a week? _____

C. Do you or have you used recreational drugs (confidential)? ☐ Y ☐ N

D. Do you have children? ☐ Y ☐ N If yes, how many? _____

E. Do you live alone? ☐ Y ☐ N

Name: _____

GENERAL SURGERY ASSOCIATES

Associated Surgical Groups

New Patient Registration and Questionnaire (Page 3)

6. Past Medical History

Do you have or have you ever been diagnosed with the following? (Please check yes or no)

Anemia	☐ Y ☐ N	Gallbladder Trouble	☐ Y ☐ N	Liver Disease	☐ Y ☐ N
Arthritis	☐ Y ☐ N	Heart Attack	☐ Y ☐ N	Pneumonia	☐ Y ☐ N
Asthma	☐ Y ☐ N	Heart Murmur	☐ Y ☐ N	Rheumatic Fever	☐ Y ☐ N
Bleeding Problems	☐ Y ☐ N	Hepatitis A, B,or C (circle)	☐ Y ☐ N	Sickle Cell Disease	☐ Y ☐ N
Cancer/Type:	☐ Y ☐ N	High Blood Pressure	☐ Y ☐ N	Sleep Apnea	☐ Y ☐ N
Colitis/Diverticulitis	☐ Y ☐ N	HIV Virus	☐ Y ☐ N	Thyroid Disease	☐ Y ☐ N
Diabetes	☐ Y ☐ N	Irregular Heartbeat	☐ Y ☐ N	Varicose Veins	☐ Y ☐ N
Emphysema/COPD)	☐ Y ☐ N	Jaundice (yellow eye)	☐ Y ☐ N	Ulcers	☐ Y ☐ N

Have you experienced any of the following?: (Please check box if yes)

General:	☐ Fever ☐ Chill ☐ Unintentional Weight Loss ☐ Excessive Fatigue
Immunologic:	☐ Tuberculosis ☐ Immunosuppression ☐ HIV
Eye:	☐ Double Vision ☐ Eye Pain ☐ Glaucoma
ENT:	☐ Ringing in ears ☐ Hearing Issues ☐ Dentures ☐ Hoarseness
Endocrine:	☐ Heat/Cold Intolerance ☐ Excessive Sweating
Respiratory:	☐ Cough ☐ Coughing-up Blood ☐ Wheezing ☐ Asthma ☐ Shortness of breath
Breast:	☐ Breast Mass ☐ Breast Skin Changes ☐ Breast Tenderness ☐ Nipple Discharge
Cardiac:	☐ Chest Pain ☐ Palpitations ☐ Shortness of breath
Gastro:	☐ Diarrhea ☐ Black Stools ☐ Constipation ☐ Blood in Stool ☐ Heartburn
Hematology:	☐ Easy Bruising ☐ Clotting Disorder ☐ Excessive Bleeding ☐ Previous Transfusion
GU:	☐ Burning When Urinating ☐ Blood in Urine ☐ Frequent Urination
Musculoskeletal:	☐ Calf Pain ☐ Weakness ☐ Joint Pain ☐ Joint Swelling ☐ Leg Swelling
Neurologic:	☐ Fainting/Blackouts ☐ Seizures
Psychiatric:	☐ Anxiety ☐ Depression ☐ Suicidal Thoughts

7. Family History

Relative	Diabetes	Stroke	Cancer	Heart Disease	High Blood Pressure	Other	
Mother							
Father							
Maternal Grandmother							
Maternal Grandfather							
Paternal Grandmother							
Paternal Grandfather							
Other:							
Other:							
Other:							

Name: _____

GENERAL SURGERY ASSOCIATES

Associated Surgical Groups

ADDENDUM (Page 4)

YOU MAY LEAVE THIS PAGE BLANK IF NO ADDITIONAL SPACE IS NEEDED

Additional Medications

Prescribed Drugs, Over the Counters, Vitamins	Currently On?		Dose	Reason for Taking
	Yes	No		

Additional Allergies

Drug	Reaction

Additional Surgical History

Procedure	Date	Location	Surgeon