M. SHANE DAWSON MD

GENERAL / LAPAROSCOPIC / ROBOTIC SURGERY

DEMOGRAPHIC INFORMATION

LAST NAME: ________________________________ FIRST NAME: _____________________________ MI: _______

DATE OF BIRTH: _____________________ SEX: ___________ SOCIAL SECURITY #: ________________________

ADDRESS: ____APT #: _______________________

CITY: _______________________________ STATE: ________________________ ZIP: ________________________

HOME PHONE: ______________________________ WORK PHONE: ______________________________________

CELL PHONE: ________________________________ EMAIL: ____

MARITAL 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: ________________________

IS THIS AN ACCIDENT? _______ YES _______ NO

DATE OF INJURY: ___________________

IS THIS A MOTOR VEHICLE ACCIDENT? _______ YES _______ NO

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

SIGNATURE OF INSURED / GUARDIAN: ___________________________________ DATE: ________________

M. SHANE DAWSON MD
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PRIMARY INSURANCE

INSURANCE COMPANY: ____
MEMBER ID #: ____ GROUP #: _____________________________
INSURED FIRST NAME: _________________________________ LAST NAME: ___________________________
SOCIAL SECURITY #: _______________________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 ____ FULL TIME STUDENT ____ PART TIME STUDENT ____ RETIRED
OCCUPATION: ______________________________ BUSINESS NAME: ________________________________

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SIGNATURE OF INSURED / GUARDIAN: _________________________________ DATE: __________________

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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 _____ PIPE TOBACCO
_____ CIGARS _____ CHEWING 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: ____

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 of Legal Guardian/Representative

____

Printed Name

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

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 Dawson General Surgery 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 INFORMATION TO ME IN THE FOLOWWING MANNERS:

VIA MAIL — PLEASE INITIAL

_____ OK TO MAIL TO HOME ADDRESS ____________

_____ OK TO MAIL TO WORK ADDRESS ____________

VIA HOME TELEPHONE

_____ OK TO LEAVE DETAILED MESSAGE ____________

_____ LEAVE CALL BACK NUMBER ONLY ____________

VIA WORK TELEPHONE

_____ OK TO LEAVE DETAILED MESSAGE ____________

_____ LEAVE CALL BACK NUMBER ONLY ____________

VIA FAX

_____ OK TO FAX TO: ________________ ______________

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

SIGNATURE OF INSURED / GUARDIAN: ___________________________________ DATE: ___________________