

**GENERAL & BARIATRIC SURGICAL ASSOCIATES
PATIENT INFORMATION – New Patient Consultation**

Last name, first, middle initial	Date of Birth	Sex	Marital Status M D S W
Street Address	Home Phone		Email Address
City State Zip	Work Phone		Cell Number
Driver License Number and State in Which Issued	Social Security Number		
Spouse's Name/Parent of Minor Child	Relationship if Minor Child		
Spouse's Employer	Work Phone	Cell Phone	
Employer's Name	Employer's Street Address		
Occupation	City	State	Zip
Emergency Contact:	Relationship		
Street Address:	Home Phone:	Work Phone:	
City State Zip	Cell Phone:		

INSURANCE INFORMATION:

Primary Insurance	Secondary Insurance
Address	Address
Customer Service Phone Number	Customer Service Phone Number
Policy or ID Number	Policy or ID Number
Name and Date of Birth for Policy Holder	Name and Date of Birth for Policy Holder
Relationship to Patient	Relationship to Patient
Social Security Number of Policy Holder	Social Security Number of Policy Holder
Insured's Employer	Insured's Employer

HOW DID YOU HEAR ABOUT US?
(Circle one and complete information)

Referring Physician	Name of Doctor: _____
Community Lecture	Date: _____
Internet	Website: _____
Radio	Station: _____
Other	_____

I authorize release of medical information necessary to process claims for health insurance and disability benefits, and request that payment be made directly to my physician for services rendered. A copy of this authorization will be accepted as valid as the original.

Signature: _____ Date: _____



GENERAL & BARIATRIC SURGICAL ASSOCIATES
FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility as our patient. We file insurance claims as a courtesy to our patients, however below is a list of guidelines that all patients must follow to assist us with the process.

- **It is every patient’s responsibility to understand their insurance policy/benefits.**
- **Payment is DUE AT THE TIME OF SERVICE.**
- **Each patient must bring their insurance information to every appointment to ensure correct processing of all insurance claims.**
- **If you are a MEDICARE patient, under federal law you are mandated to pay your deductible and 20% co-payment.**
- **All patients must complete and sign our FINANCIAL POLICY before care is rendered.**
- **There is a \$25.00 service fee for all returned checks**
- **If correspondence from your insurance company has not been received within 45 days of claim submission by GBSA patients may be responsible for charges they have acquired.**
- **If your insurance company needs any additional information it is your responsibility to provide it to them.**

PATIENT OR RESPONSIBLE PARTY:

I have read, understand, and have been allowed to ask questions regarding this policy and agree to comply with the guidelines hereunder described.

Print Name: _____

Signature: _____ Date: _____

Today I will be paying by: (please circle selection)

Check Cash Visa Mastercard AMEX Money Order

**GENERAL & BARIATRIC SURGICAL ASSOCIATES
MEDICAL HISTORY**

Patient Name: _____ Age: _____

Reason for Visit: _____

For Doctor's Notes: _____

Name Address Phone

Primary Care Physician: _____

Gynecologist: _____

Other: _____

PAST & CURRENT MEDICAL HISTORY

Please circle any of the following conditions/problems/disease that you either now have or have been diagnosed with in the past:

- | | | | |
|-------------------------------------|--------------------|----------------------------|-------------------------|
| Abuse (Physical/Mental/Sexual/etc.) | Blood Clots | Glaucoma/Cataract | Lung disease |
| Abnormal PAP | Cancer/Tumor | Gout | Osteoporosis |
| Alcoholism/Drugs | Cholesterol (high) | Headaches/Migraine | Serious accident/Injury |
| Anemia | Chronic Pain | Heart disease | Sexual disease/VD |
| Anxiety/Nerves | Depression | Hepatitis (Any) | Stroke |
| Arthritis | Diabetes/Sugar | High Blood pressure | Thyroid Disease |
| Asthma/Allergies | Epilepsy/Seizures | HIV/AIDS | Tuberculosis |
| Bleeding disease | Genetic diseases | Kidney or Bladder problems | Ulcers/Stomach disease |

Others: _____

PAST SURGICAL HISTORY: *List the year you had any of the following*

- | | |
|---------------------------------------|--------------------------------|
| <i>Appendectomy</i> _____ | <i>Gallbladder</i> _____ |
| <i>Hernia</i> _____ | <i>Tonsillectomy</i> _____ |
| <i>Blood Transfusion</i> _____ | <i>Heart / Cardiac</i> _____ |
| <i>Hysterectomy</i> _____ | <i>Tubal / Vasectomy</i> _____ |
| <i>Stress Test/Cardiac Cath</i> _____ | <i>Orthopedic</i> _____ |
| <i>Other</i> _____ | <i>Other</i> _____ |

CURRENT MEDICATIONS: *List all medications that you take routinely or that have been prescribed for you by a doctor (include vitamins, over-the-counter medications, eye drops, herbal medications, etc.)*

MEDS	DOSE	HOW OFTEN	MEDS	DOSE	HOW OFTEN

*Attach a medication list or ask for another sheet of paper if medications exceed the space given

