

Dr. Grischow

Dr. Brown

Dr. Davanzo

Dr. Giammar

Please mark the box next to your doctor

**PATIENT INFORMATION SHEET**

**PATIENT INFORMATION (Please Print and Complete Fully)**

Legal Name: \_\_\_\_\_  
(Last) (First) (Initial) (Maiden)

Address: \_\_\_\_\_  
(Street Address) (City) (State) (Zip)

SS#: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Gender: Male Female Marital Status: Single Married Widowed Divorced Separated

Phone: Home ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

★ Email address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

★ Primary Care/Family Physician: \_\_\_\_\_

★ Referring Physician (if different): \_\_\_\_\_

➔ Do you have Medicare insurance? Yes No If yes, please present your card at the desk

[Please note that there are Medicare *supplement* plans, and Medicare *replacement* plans. If you have both Medicare and a supplement, Medicare is your primary insurance and your supplement goes in the secondary section. If you have a replacement plan (such as Medigold), that is your primary insurance NOT Medicare. Please fill out the following sections accordingly and present your cards]

**PRIMARY INSURANCE**

Name of Insurance and Member ID #: \_\_\_\_\_

Policy Holder: (circle one) Spouse Parent Self **\*\*If address/phone are the same as above, you may leave demographics blank\*\***

Name: \_\_\_\_\_  
(Last) (First) (Initial)

Address: \_\_\_\_\_  
(Street Address) (City) (State) (Zip)

Phone: Home ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

SS#: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**SECONDARY INSURANCE**

Name of Insurance and Member ID #: \_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

**Have you had an anesthetic procedure (surgery, colonoscopy, EGD etc) in the past year?**

**Yes    No**

If yes, which procedure(s)? \_\_\_\_\_

Where was procedure performed? \_\_\_\_\_

**Have you had any testing (MRI, CT Scan, X-Ray, Ultrasound, Bloodwork, EKG) in the past year?**

**Yes    No**

If yes, which test(s)? \_\_\_\_\_

Where? \_\_\_\_\_

**Have you been to the Emergency Room in the past year?**

**Yes    No**

If yes, where? \_\_\_\_\_

**When was your last physical with your family doctor? \_\_\_\_\_**

**Patient Acknowledgement of Receipt of the Notice of Privacy Practices,  
Medical Records Release, Approval of Contact and Financial Responsibility**

I, the undersigned, authorize the release of medical information to my primary care or referring physician and to consultants if necessary, including work release forms. By signing this form, I am acknowledging receipt of the Notice of Privacy Practices of Westerville Surgical Specialists. Westerville Surgical Specialists reserves the right to change the privacy practices that are described in the Notice of Privacy Practices and I may obtain a revised Notice of Privacy Practices by calling the office.

**\*Please indicate any persons/groups you do not wish your records to be released to:**

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I authorize my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address provided.

I, the undersigned, certify that I (or my dependent) have health insurance or Medicare/Medicaid and assign directly to Westerville Surgical Specialists all of these benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for any deductibles, coinsurance, co-pays, non-covered services, and anything considered “not medically necessary” by my insurance company, or charges that are not paid by my specific insurance company. I understand that if I do not have health insurance I am financially responsible for any and all charges for services rendered by Westerville Surgical Specialists. I understand that all copays and fees are due at the time of service. I certify that the information provided by me for payment and services is correct. I authorize Westerville Surgical Specialists to release any necessary information needed to determine liability for payment and to obtain reimbursement on any claim.



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SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE

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PRINTED NAME

DATE OF BIRTH

# HEALTH HISTORY

Confidential

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Date of last physical examination \_\_\_\_\_

What is your reason for visit? \_\_\_\_\_

<b>SYMPTOMS</b> Check (✓) symptoms you currently have or have had in the past year.				
<p><b>GENERAL</b></p> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	<p><b>GASTROINTESTINAL</b></p> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood	<p><b>EYE, EAR, NOSE, THROAT</b></p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision – Flashes <input type="checkbox"/> Vision – Halos	<p><b>MEN only</b></p> <input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other	
<p><b>MUSCLE/JOINT/BONE</b></p> Pain, weakness, numbness in: <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<p><b>CARDIOVASCULAR</b></p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	<p><b>SKIN</b></p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal	<p><b>WOMEN only</b></p> <input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other	
<p><b>GENITO-URINARY</b></p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination				Date of last menstrual period _____ Date of last Pap Smear _____ Have you had a mammogram? _____ Are you pregnant? _____ Number of children _____

<b>CONDITIONS</b> Check (✓) conditions you have or have had in the past.			
<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts	<input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio	<input type="checkbox"/> Prostate Problem <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Venereal Disease

<b>MEDICATIONS</b> List medications you are currently taking.	<b>ALLERGIES</b> To medications or substances
Pharmacy Name _____	Phone _____



## Notice of Privacy Practices

Westerville Surgical Specialists  
477 Cooper Rd. Suite 440  
Westerville, OH 43081  
614-898-5561

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Protected health information (PHI) about you is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e. name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or showing this information with other healthcare professionals involved in your care or treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

### Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

**You have the right to receive, and we are required to provide you with a copy of this Notice of Privacy Practices.** We are required to follow the terms of this notice. We reserve the right to change the terms of our notice at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on its web site.

**You have the right to authorize either use and disclosure.** This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**You have the right to request an alternative means of confidential communication.** This means you have the right to ask us to contact you about medical matters using an alternative method (i.e. email, telephone) and to a destination (i.e. cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

**You have the right to inspect and copy your PHI.** This means you may inspect and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

**You have the right to request a restriction of your PHI.** This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restrictions, we will abide by it, except in emergency circumstances when information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

**You may have the right to request an amendment to your protected health information.** This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

**You have the right to request a disclosure accountability.** This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

**You have the right to receive a privacy breach notice.** You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, **please feel free** to contact our Privacy Manager. Contact information is provided under Privacy Complaints.

## **How We May Use or Disclose Protected Health Information**

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

**Treatment** – We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

**Special Notices** – We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fundraising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and with each such notice will include instructions for opting out.

**Payment** – Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

**Healthcare Operations** – We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

**Health Information Organization** – The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

**To Others Involved in Your Healthcare** – Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, or your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI then your healthcare provider may, using professional judgement, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

**Other Permitted and Required Uses and Disclosures** – We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroner; funeral director; organ donations; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

## **Privacy Complaints**

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

Westerville Surgical Associates  
477 Cooper Rd. Suite 440  
Westerville, OH 43081

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We will not retaliate against you for filing a complaint.