Westerville Surgical Associates

Dr. Grischow ☐ Dr. Brown ☐ Dr. Davanzo ☐

Dr. Murphy ☐ Dr. Babbitt ☐

Please mark the box next to your doctor Appointment:_____

PATIENT INFORMATION SHEET

PATIENT INFORMATION (Please Print and Complete Fully)

Legal Name: _____
(Last) (First) (Middle 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_____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Email address: _____

Employer: _____ Occupation: _____

★ **Pharmacy Name:**_____ **Phone:** _____

★ **Primary Care/Family Physician:** _____ **Phone:** _____
(FIRST AND LAST NAME)

★ **Referring Physician (if different):** _____ **Phone:** _____
(FIRST AND LAST NAME)

INSURANCE INFORMATION

****It is the patient's responsibility to determine network coverage/benefits at the time of service****

Do you have insurance? Yes No

PRIMARY INSURANCE: _____

SECONDARY INSURANCE: _____

TRICARE INSURANCE MEMBERS ONLY

Sponsor Name: _____ **Birthdate:** _____ **SS#:** _____

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RELEVANT MEDICAL HISTORY

Have you had any of the following imaging in the past year? (check all that apply)

	Body Part *(example: neck, abdomen)*	Facility *(example: COPC, St. Ann's, etc.)*
☐ **MRI**	_____	_____
☐ **CT/CAT Scan**	_____	_____
☐ **X-Ray**	_____	_____
☐ **Ultrasound**	_____	_____
☐ **EKG/ECG**		_____
☐ **HIDA Scan**		_____
☐ **Mammogram**		_____
☐ **Other:** _____		_____

When was the last time you had **bloodwork**: _____ Where: _____

Have you ever had a **blood transfusion**? Yes No When: _____

Have you had any of the following procedures **in the past 5 years? (**please check all that apply)

☐ **EGD**	Doctor:_____	Facility: _____
☐ **Upper GI**	Doctor:_____	Facility: _____
☐ **Colonoscopy**	Doctor:_____	Facility: _____

Have you ever had a **hernia repair surgery** before**?**

Yes **No**

If yes, which hospital? _____ Year: _____

Surgeon's Name: _____

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

Yes **No**

If yes, where? _____

Reason: _____

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

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 listing authorized parties and signing this form, I am acknowledging receipt of the Notice of Privacy Practices of Westerville Surgical Associates. Any additional persons/ groups not listed in those which you wish to receive medical information, will require additional authorization by the patient. I may revoke this authorization in writing at any time, except for information, which has already been released in accordance with this authorization prior to my revocation. Westerville Surgical Associates reserves the right to change the privacy practices that are described in the Notice of Privacy Practices and I may contact the office to obtain a revised Notice of Privacy Practices.

***Please indicate ALL PERSONS/GROUPS YOU WISH TO RELEASE your records to:**

_____

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 and/or other electronic communication to contact me or any contacts provided by me, insurance, or other healthcare providers, for any reason by using any telephone number, email address and/or mailing address associated with my account.

I, the undersigned, certify that I (or my dependent) have health insurance or Medicare/Medicaid and assign directly to Westerville Surgical Associates all of these benefits, if any, otherwise payable to me for services rendered. I understand that it is my responsibility to ensure that I have insurance coverage with my provider and that I am financially responsible for all in or out-of-network services provided by Westerville Surgical Associates. I am responsible for providing accurate and up-to-date insurance and identifying information. 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 Associates. If I am unable to provide proper identification or cannot present a physical insurance card and proof of insurance at the time of service, I will be treated as if I do not have health insurance and am financially responsible for any and all charges for services rendered by Westerville Surgical Associates. 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 Associates to release any necessary information needed to determine liability for payment and to obtain reimbursement on any claim.

I acknowledge that upon signing, I have been made aware of Westerville Surgical Associates' cancellation policy. Under this policy, after two instances of canceling less than 48 hours prior, or not arriving to my office visit I will be charged $25. I also acknowledge that I will be charged $150 for canceling less than 48 hours prior or not arriving to any anesthetic procedure. These charges must be paid in full before I am able to reschedule an appointment or anesthetic procedure.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

PRINTED NAME DATE OF BIRTH

Westerville Surgical Associates

Patient Health History

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for today's visit? _____ ☐ Urgent? Explain _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

CONSTITUTION
- ☐ Activity change
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Poor appetite
  - ☐ Excessive hunger
  - ☐ Excessive thirst
- ☐ Sweats
- ☐ Unexpected weight change
- ☐ None

HEAD, EARS, NOSE & THROAT
- ☐ Bleeding gums
- ☐ Hoarseness
- ☐ Nosebleeds
- ☐ Trouble swallowing
- ☐ None

RESPIRATORY
- ☐ Apnea
- ☐ Chest tightness
- ☐ Persistent cough
- ☐ Shortness of breath
- ☐ None

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Bloating
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Rectal pain
- ☐ Vomiting
- ☐ None

GENITOURINARY
- ☐ Difficulty urinating
- ☐ Flank pain
- ☐ Frequency
- ☐ Genital sore
- ☐ Hematuria
- ☐ Painful urination
- ☐ Urgency
- ☐ None

EYES
- ☐ Blurred vision
- ☐ Yellowing of eyes
- ☐ None

MUSCULAR
- ☐ Back pain
- ☐ Muscle pain
- ☐ None

SKIN
- ☐ Pallor
- ☐ Rash
- ☐ Wound
- ☐ Yellowing of skin
- ☐ None

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins
- ☐ None

HEMATOLOGIC
- ☐ Bruises/bleeds easily
- ☐ Swollen lymph nodes
- ☐ None

PSYCHIATRIC
- ☐ Agitation
- ☐ Behavior problem
- ☐ Confusion
- ☐ Nervous/anxious
- ☐ Sleep disturbance
- ☐ Suicidal ideas / attempts
- ☐ None

MEN only
- ☐ Breast lump
- ☐ Penis discharge
- ☐ Penile pain
- ☐ Testicular pain
- ☐ Testicular mass
- ☐ None

WOMEN only
- ☐ Breast lump
- ☐ Nipple discharge

  Date of last mammogram _____
- ☐ Family history of breast cancer

  Age _____

  Relation _____
- ☐ None

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Bipolar
- ☐ Bleeding disorder / clot
- ☐ Cancer (type _____)
- ☐ Other _____
- ☐ Other _____
- ☐ Cirrhosis
- ☐ Connective tissue disease

  Type _____
- ☐ Depression
- ☐ Diabetes (type _____)
- ☐ Drug abuse
- ☐ Emphysema (COPD)
- ☐ Epilepsy
- ☐ Other _____
- ☐ Other _____
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ History of wound
- ☐ HIV positive
- ☐ Hypothyroidism/thyroid disease
- ☐ Other _____
- ☐ Other _____
- ☐ Infection
- ☐ Kidney disease
- ☐ Pace maker
- ☐ Schizophrenia
- ☐ Sleep apnea
- ☐ STD
- ☐ Stroke
- ☐ Ulcer
- ☐ Unhealed sores
- ☐ Other _____

RECENT HOSPITALIZATIONS / SURGERIES

YEAR	HOSPITAL	REASON / SURGERY TYPE / OUTCOME

☐ Bryan Grischow, DO ☐ R. Shane Brown, MD ☐ Brandon Murphy, MD ☐ Brian Davanzo, MD ☐ Casey Babbitt, MD

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Patient Health History

(page 2)

Patient Name _____ Today's Date _____

ALLERGIES To medications, etc.

ALLERGY	ALLERGIC REACTION

MEDICATIONS List current medications

	MEDICATION NAME	DOSE	TIMES PER DAY		MEDICATION NAME	DOSE	TIMES PER DAY
1				6			
2				7			
3				8			
4				9			
5				10			

Pharmacy Name _____ **Phone** _____

FAMILY HISTORY Check (✓) if your blood relatives had any of the following:

	RELATIONSHIP TO YOU		DISEASE	RELATIONSHIP TO YOU
☐	Asthma, Hay Fever		☐ High Blood Pressure	
☐	Bleeding / clotting disorder		☐ Kidney Disease	
☐	Cancer		☐ Other	
☐	Chemical Dependency		☐ Other	
☐	Diabetes		☐ Other	
☐	Heart Disease, Strokes		☐ Other	

SOCIAL HISTORY Check (✓) what applies to you.

Smoke cigarettes? ☐ N ☐ Y **Current:** Packs/Day _____ # of Years_____

Past: Quit Date: _____ Packs/Day _____ # of Years _____

Other Tobacco: *Check (✓) all that apply* ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol Use: Do you drink alcohol? ☐ N ☐ Y ☐ Beer ☐ Wine ☐ Liquor # of Drinks/Week _____

Drug Use: Do you use marijuana or other recreational drugs? ☐ N ☐ Y

Have you ever used needles to inject drugs? ☐ N ☐ Y

Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____

Employment Status: ☐ Employed F/T ☐ Employed P/T ☐ Retired ☐ LOA ☐ Disabled ☐ Unemployed

Educational History: Years of education or Highest Degree: _____

SIGNATURE & ACKNOWLEDGEMENT Please read and sign below

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the physician/provider of any changes in my medical status and of my current list of medications.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

Reviewed by — Date