Columbia Surgical Associates
3220 Bluff Creek Drive, Suite100 Columbia, Missouri 65201
Phone: (573) 443-8773 Fax: (573) 875-4972

Place Patient Sticker Here

Patient Information

First Name:_____ **Last Name:**_____ **Middle Initial:**_____

Date of Birth:_____ **Sex:** ☐Male ☐Female

Social Security #_____ **Marital Status:** ☐Single ☐Married ☐Divorced ☐Widowed

Ethnicity: ☐Non-Hispanic ☐Hispanic

Race: ☐White ☐African American ☐Asian ☐Pacific Islander ☐American Indian ☐Unknown ☐Decline to Say

Preferred Language: ☐English ☐Spanish ☐Other:_____

Street Address: _____ **City:**_____ **State:**_____ **Zip:**_____

Home Phone:_____ **Cell Phone:**_____ **Email:**_____

Communication Preference: ☐Home Phone ☐Cell Phone ☐Mail ☐Email

Employer:_____ **Work Phone:**_____ **EXT:**_____

Which Doctor Are You Seeing Today?_____

Referring Doctor 1:_____ **Phone:**_____

Referring Doctor 2:_____ **Phone:**_____

Family Doctor:_____ **Phone:**_____

Emergency Contact:_____ **Relation:**_____ **Phone:**_____

Insurance Information

Primary Insurance Company:_____

Name of Insured:_____ **DOB:**_____

I.D. #_____ **Group #:**_____ **SS #:**_____

Effective Date of Coverage:_____ **Relationship to Patient:**_____

Employer:_____

Secondary Insurance Company:_____

Name of Insured:_____ **DOB:**_____

I.D. #_____ **Group #:**_____ **SS #:**_____

Effective Date of Coverage:_____ **Relationship to Patient:**_____

Employer:_____

Patient Authorization

_____ _____ _____

Patient Signature Date (Power of Attorney or Authorized Signature if Minor)

I understand that I am responsible for my payment of services to Columbia Surgical Associates, I authorize the release of any and all medical records information necessary to process claims and requests for payment from my Insurance Company in compliance with HIPAA regulations. Further, I understand that certain procedures may not be covered by my insurance company and, in such situations I understand I will be responsible for payment for such services.

Workers Compensation/Auto Accident Liability Information

Is your visit today related to a work injury? ☐Yes ☐No
Is your visit today related to an auto accident? ☐Yes ☐No
Is your visit today related to any other liability claim? ☐Yes ☐No

If you have answered "NO" to all of the questions above, please sign below:

Patient Signature:_____Date:_____

If you answered "YES" to any of the questions above, please complete the rest of this form and sign below:

Do you have authorization from the insurance carrier for today's visit: ☐Yes ☐No

Has this claim been filed with the Missouri State Department of Workers Compensation:
☐Yes ☐No

If "YES" please provide the Report of Injury Number:_____

I authorize Columbia Surgical Associates, Inc. and/or its representatives to release my medical records information and/or discuss continued treatment of care with the designated insurance company or Workers Compensation carrier or its representatives as necessary to process claims and requests for payment.

Patient Signature:_____Date:_____

HIPAA Authorization

I have been informed by Columbia Surgical Associates that the "**Notice of Information Practices**" is available in the waiting room for review. I understand that I have the right to ask question in order to seek clarification and/or request a copy of this document. Any medical or billing may be discussed with the following.

☐	**No information to be released to anyone**
☐	**No information to be released without password**
☐	**Release information to see contact grid**
☐	**Patient unable to address at this time**

Information Release Password

Patient Contacts	Release of Medical Info/PHI	Relationship	Primary Phone	Alternative Phone

Patient Signature:_____Date:_____

Place Patient Sticker Here

Patient Name:_____ **Date of Birth**:_____

History of Present Illness

Reason for today's visit:_____

What makes this better or worse:_____

Date illness started:_____ **Severity of pain 1-10 (10 being worst):**_____

Quality of pain (stabbing/pressure-like/etc.):_____

Vitals (Will be completed by nursing staff)

Height:_____ **Weight:**_____ **Pulse:**_____ **BP:**_____

Surgical History

Please list all surgeries:

	Surgery	Year	Complications/Details
	Colonoscopy		
	Prostate Surgery		
	Hernia		
	Gall Bladder		
	Appendectomy (Appendix)		
	Hysterectomy w/ or w/o Removal of Ovaries		
	Heart Catheterization		
	Heart Bypass		
	Any Vascular Surgeries (Please Explain)		
	Breast		
	Thyroid		
	Other:		
	Other:		

Please list all Hospitalizations:

Hospitalization Reason	Date	Hospital

Preferred Learning Style(s):

☐Computer if available	☐Discussion	☐TV/Video if available
☐Demonstration	☐Reading material/handouts	☐Other:_____

For Women Only

Do you think you may be currently pregnant: ☐Yes ☐ No

How many times have you been pregnant:_____

What age were you at your first pregnancy:_____

How many children do you have:_____

What age did you start having periods:_____

Are you still having regular menstrual cycles: ☐Yes ☐ No

Are you now on or have you ever been on Hormone Replacement Therapy: ☐Yes ☐ No

Have you had a mammogram: ☐Yes ☐ No

If **YES**, When:_____Results: ☐Normal ☐Abnormal

For Men Only

Do you have any prostate issues: ☐Yes ☐ No If yes, explain:_____

Have you had a prostate exam: ☐Yes ☐ No If yes, when:_____

Have you had a PSA (Prostate Specific Antigen) test: ☐Yes ☐ No

If **YES**, When:_____Level:_____

Social History

Who lives in your home:_____

Are you currently working: ☐Yes ☐ No

Reason (if **No**) ☐Unemployed ☐Retired ☐Disabled ☐Other:_____

Your Occupation:_____☐Full-Time ☐Part-Time ☐Student

Do you smoke: ☐Yes ☐ No/Former ☐ No/Never

If **Yes** or **Former** than: (Stopped:_____) Packs Per Day:_____

Do you use other tobacco products: ☐Yes ☐ No/Former ☐ No/Never

If **Yes** or **Former** than: (Stopped:_____) Packs Per Day:_____

Do you Drink Alcohol: ☐Yes ☐ No

If **YES**, How Often: ☐Rarely (1-2 a year) ☐Daily ☐Weekly (1-2) ☐Monthly (1-2)

Do you drink more than 6 cups of caffeinated beverages per day: ☐Yes ☐ No

Patient Name:_____**Date of Birth**:_____

Family Medical History

Please check "Yes" and list the relation if any family members suffer from any of the conditions below. Check "No" if no family members suffer from any of the listed conditions.

			Family Member
Asthma	☐Yes	☐No	
Abdominal Aneurysm	☐Yes	☐No	
Bleeding Disorder	☐Yes	☐No	
Blood Clots	☐Yes	☐No	
Cancer – Breast	☐Yes	☐No	
Cancer – Colon	☐Yes	☐No	
Cancer - Uterine	☐Yes	☐No	
Cancer - Ovarian	☐Yes	☐No	
Cancer – Other:_____	☐Yes	☐No	
Colon/Rectal Polyps	☐Yes	☐No	
Diabetes	☐Yes	☐No	
Emphysema	☐Yes	☐No	
Heart Attack	☐Yes	☐No	
Heart Disease	☐Yes	☐No	
Hepatitis	☐Yes	☐No	
High Blood Pressure	☐Yes	☐No	
High Cholesterol	☐Yes	☐No	
Kidney Disorder	☐Yes	☐No	
Liver Disease	☐Yes	☐No	
Malignant Hyperthermia	☐Yes	☐No	
Multiple Sclerosis	☐Yes	☐No	
Problems with Anesthesia:_____	☐Yes	☐No	
PVD (Peripheral Vascular Disease)	☐Yes	☐No	
Stroke	☐Yes	☐No	
Thyroid Disorder	☐Yes	☐No	
Tuberculosis	☐Yes	☐No	
Ulcerative Colitis / Crohn's Disease	☐Yes	☐No	

The above information is completed to the best of my knowledge

Patient Signature:_____Date:_____

Current Medication List

Pharmacy:	Street and City:	Phone Number:

Allergies:			Reaction:
Do you Suffer from a Latex Allergy/Sensitivity:	☐Yes	☐No	

Prescription/Over the Counter Medication Name:	Dosage:	Frequency:	Route/Topical Site:

Herbal Medication Name:	Dosage:	Frequency:	Route/Topical Site

Place Patient Sticker Here

Patient Name:_____ **Date of Birth**:_____

Do you now or have you recently had any problems related to the following systems? Check Y (Yes) or N (No). If you mark Yes to any of the following, please indicate which doctor is treating you for that problem. If you haven't seen a physician yet, please contact your Internist or Family Physician to address those issues.

Review of Systems

Cardiovascular:			**Hematological/Lymphatic:**			**Respiratory:**		
Chest Pain	☐Y	☐N	Persistent Enlarged Glands	☐Y	☐N	Wheezing	☐Y	☐N
Palpitations	☐Y	☐N	Blood Clotting Problems	☐Y	☐N	Frequent Cough	☐Y	☐N
Murmur	☐Y	☐N	Bleeding Problems	☐Y	☐N	Chronic Cough	☐Y	☐N
Leg Swelling	☐Y	☐N	**Musculoskeletal:**			Shortness of Breath	☐Y	☐N
Irregular Heartbeat	☐Y	☐N	Joint Pain	☐Y	☐N	**Gastrointestinal:**		
Constitutional Symptoms:			Neck Pain	☐Y	☐N	Abdominal Pain	☐Y	☐N
Fever	☐Y	☐N	Back Pain	☐Y	☐N	Nausea	☐Y	☐N
Chills	☐Y	☐N	Assistive Devices	☐Y	☐N	Vomiting	☐Y	☐N
Weight Loss	☐Y	☐N	**Neurological:**			Intolerance to Greasy Foods	☐Y	☐N
Weight Gain	☐Y	☐N	Headache	☐Y	☐N	Blood in Stool	☐Y	☐N
Endocrine:			Seizures	☐Y	☐N	Jaundice	☐Y	☐N
Excessive Thirst	☐Y	☐N	Tremors	☐Y	☐N	Incontinence of Stool	☐Y	☐N
Hot/Cold Intolerant	☐Y	☐N	Dizzy Spells/Fainting	☐Y	☐N	Difficulty Swallowing	☐Y	☐N
Tired	☐Y	☐N	Numbness/Tingling	☐Y	☐N	Reflux/Heartburn Indigestion	☐Y	☐N
Genitourinary:			Weakness	☐Y	☐N	Colon/Rectal Polyps	☐Y	☐N
Urine Retention	☐Y	☐N	**Skin:**			**Psychological:**		
Painful Urination	☐Y	☐N	Changes in hair or nails	☐Y	☐N	Do you feel Anxious/Nervous	☐Y	☐N
Urinary Frequency	☐Y	☐N	Change in skin color	☐Y	☐N			
Difficulty Urinating	☐Y	☐N	Itching	☐Y	☐N	**Allergic and Immune:**		
Incontinence	☐Y	☐N	Rash	☐Y	☐N	Allergic reaction to medication or x-ray dye	☐Y	☐N
Eyes:			**Ear, Nose, Mouth and Throat**					
Blurred vision	☐Y	☐N	Loss of sense of smell	☐Y	☐N			
Double vision	☐Y	☐N	Hearing loss	☐Y	☐N			
Loss of vision	☐Y	☐N	Ringing in your ears	☐Y	☐N			

Other:

Personal Medical History

Please Check "Yes" for any medical conditions YOU suffer from and check "No" if you do not suffer from the condition

Anemia	☐Yes	☐No	Heart Disease	☐Yes	☐No
Arthritis	☐Yes	☐No	Hepatitis	☐Yes	☐No
Asthma	☐Yes	☐No	Hiatal Hernia	☐Yes	☐No
Atrial Fibrillation /Irregular Heartbeat	☐Yes	☐No	High Blood Pressure	☐Yes	☐No
Blood Clots	☐Yes	☐No	High Cholesterol	☐Yes	☐No
(Had a) Blood Transfusion	☐Yes	☐No	Kidney Stones	☐Yes	☐No
Cancer – Breast	☐Yes	☐No	Liver Disease	☐Yes	☐No
Cancer – Colon	☐Yes	☐No	Malignant Hyperthermia	☐Yes	☐No
Cancer – Other:	☐Yes	☐No	Meningitis	☐Yes	☐No
Chronic Pain	☐Yes	☐No	Multiple Sclerosis	☐Yes	☐No
Cirrhosis of the Liver	☐Yes	☐No	Pneumonia	☐Yes	☐No
Colon/Rectal Polyps	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
Depression	☐Yes	☐No	Stroke	☐Yes	☐No
Diabetes	☐Yes	☐No	Thyroid Disorder	☐Yes	☐No
Emphysema/COPD	☐Yes	☐No	Tuberculosis	☐Yes	☐No
PVD Peripheral Vascular Disease	☐Yes	☐No	Ulcers – Leg	☐Yes	☐No
Epilepsy/Seizures	☐Yes	☐No	Ulcers - Stomach	☐Yes	☐No
Freq. Headache/Migraine	☐Yes	☐No	Varicose Veins	☐Yes	☐No
GERD	☐Yes	☐No	Paralysis	☐Yes	☐No
Head Injury	☐Yes	☐No	Renal Failure	☐Yes	☐No
Hearing Loss	☐Yes	☐No	Sleep apnea - CPAP	☐Yes	☐No
Heart Attack	☐Yes	☐No	Sleep apnea - BiPAP	☐Yes	☐No

Please list any major or chronic illnesses not listed above: ☐ **None**

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