MU Health Care

Columbia Surgical Associates
3220 Bluff Creek Drive, Suite 100
Columbia, MO 65201
PHONE 573-443-8773
WEB www.columbiasurgical.com

PLEASE COMPLETE ALL FORMS BEFORE YOUR APPOINTMENT TO ENSURE THAT YOU ARE SEEN IN A TIMELY MANNER. PLEASE BRING PHOTO IDENTIFICATION, INSURANCE CARDS AND CURRENT

Dear Patient:

Enclosed you will find information regarding your appointment with MU Health Care Columbia Surgical Associates. **Please note: this is an office consultation visit only; no major surgery will be performed at this visit although minor diagnostic procedures may be performed (i.e. anoscopy, biopsy or an ultrasound). Your insurance co-pay will be due at the time of service. You can make payments by cash, check, money order, MasterCard, Visa, and Discover.**

Please bring the completed two sided forms with you to your appointment and arrive 15 to 30 minutes prior to your appointment time so that we may get your insurance information scanned into our system. The map to our location is on the back of this letter.

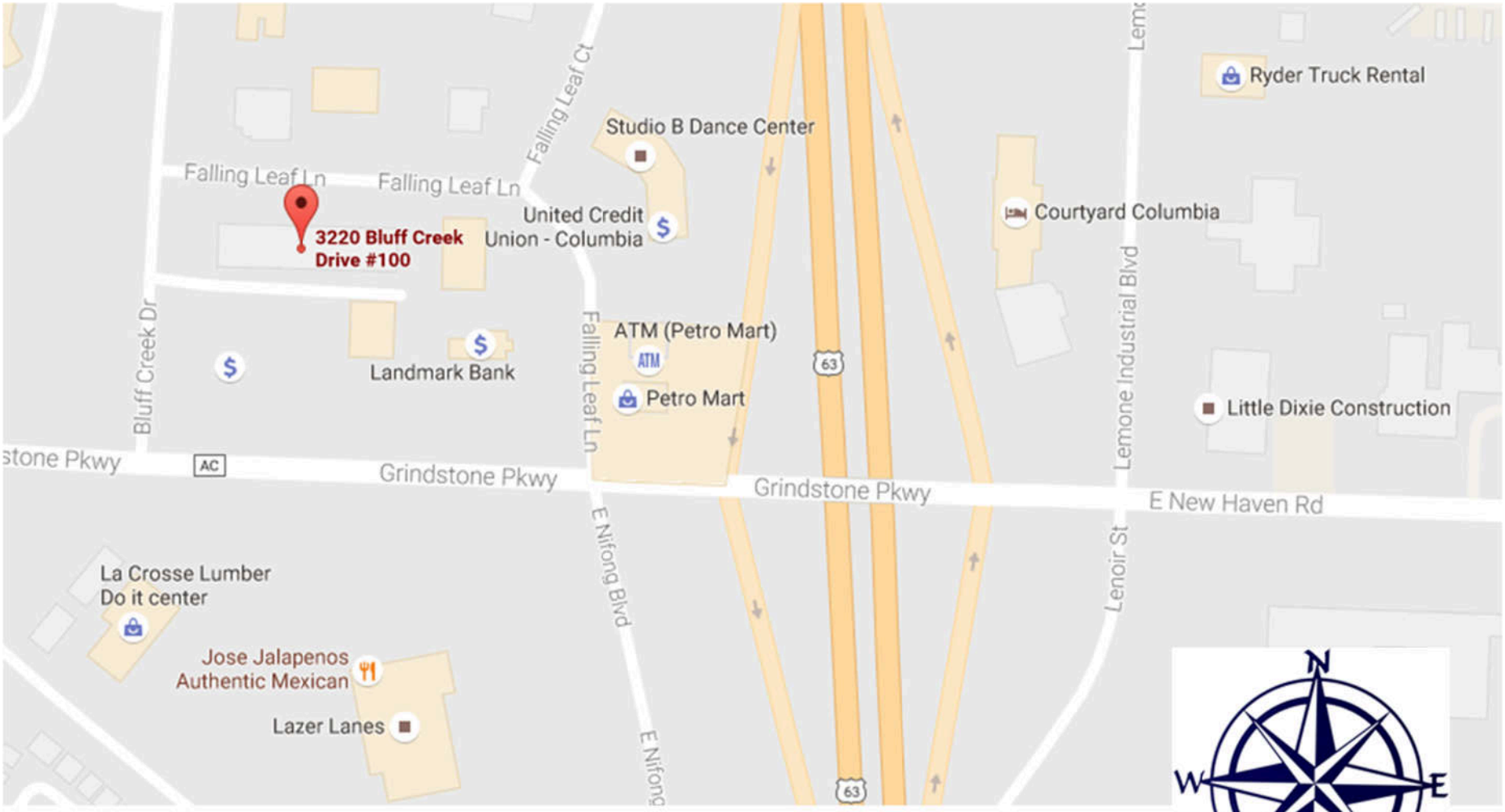
Your insurance company may require a referral form from your primary care physician (listed on your insurance card) so it is important that you contact their office prior to your appointment. This will assure that your visit with us will be covered by your health insurance plan. **Also, if you have had any recent x-rays (including mammograms), lab work, EKG's or any tests that pertain to the problem you are being seen for,** please bring them with you to your appointment.

If you are unable to keep your appointment, please notify us 24 hours prior to the scheduled time. We will make every effort to change the appointment to a more acceptable time.

If you have any questions about your appointment, feel free to call our office Monday through Friday, 8:00 a.m. to 5:00 p.m.

Sincerely,
Physicians and Staff
MU Health Care Columbia Surgical Associates

North to Stadium & Broad Way /Kirksville



South Discovery Parkway to Jefferson City

MU Health Care

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:_____

HIPAA Authorization

I have been informed by MU Health Care 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 questions in order to seek clarification and/or request a copy of this document. Any medical or billing information may be discussed with the following people.

☐	**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:_____

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

Nurse Only:

Pulse:_____

BP:_____

Weight:_____

Height:_____

BMI:_____

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.):_____

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 (Not listed above):

Hospitalization Reason	Date	Hospital

Preferred Learning Style(s):

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

Place Patient Sticker Here

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:_____

Date of last menstrual cycle: _____

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

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: ☐ No/Never ☐ Former/Quit-Date: _____

☐**Yes** , I am interested in quitting. ☐Yes, Not interested in quitting

Packs Per Day:_____

Do you use other tobacco products: ☐ No/Never ☐ Former/Quit-Date: _____

☐**Yes** , I am interested about quitting. ☐Yes, Not interested in quitting

Amount Per Day:_____

Do you Drink Alcohol: ☐Yes ☐ No

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

☐**Yes** , I am interested in quitting. ☐Yes, Not interested in quitting

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

Patient Signature:_____**Date**:_____

Family Medical History

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

☐ Unknown/Adopted			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	
Heart Attack	☐Yes	☐No	
Hepatitis \ Liver Disease	☐Yes	☐No	
High Blood Pressure	☐Yes	☐No	
High Cholesterol	☐Yes	☐No	
Kidney Disorder	☐Yes	☐No	
Malignant Hyperthermia	☐Yes	☐No	
Problems with Anesthesia:_____	☐Yes	☐No	
PVD (Peripheral Vascular Disease)	☐Yes	☐No	
Stroke	☐Yes	☐No	
Ulcerative Colitis	☐Yes	☐No	
Crohn's Disease	☐Yes	☐No	

The above information is completed to the best of my knowledge

Patient Signature:_____Date:_____

Place Patient Sticker Here

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

Other:

Advanced Directive

Do you have an advanced directive? ☐Yes ☐No

If **No,** would you like information about setting up one? ☐Yes ☐No

If **Yes**, will you provide a copy for your medical record? ☐Yes ☐No

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
History of 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
GERD	☐Yes	☐No	Varicose Veins	☐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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INSURANCE TERMS AND DEFINITIONS

DEDUCTIBLE: AMOUNT OF EXPENSES THAT MUST BE PAID OUT OF POCKET BEFORE AN INSURER WILL PAY ANY EXPENSES.

CO-INSURANCE: A PERCENTAGE OF PATIENT'S FINANCIAL RESPONSIBILITY.

CO-PAY: A PAYMENT DEFINED IN THE INSURANCE POLICY PAID BY THE INSURED PERSON AT THE TIME OF OFFICE APPOINTMENT.

OUT-OF-POCKET MAXIMUM: TOTAL MAXIMUM AMOUNT PAID BY PATIENT OUT OF POCKET IN A BENEFIT PERIOD.

FACILITY: LOCATION WHERE PATIENT'S SURGICAL PROCEDURE IS PERFORMED.

SURGEON: PROFESSIONAL THAT PERFORMS THE PATIENT'S PROCEDURE.

There will usually be 2 to 4 charges in connection to your procedure. The first charge will be the facility charge. The facility charge will come from Columbia Surgical Center, University Hospital, or Boone Hospital. Although the Surgical Center is located in the same building, they will be charging the facility charge because their location is used by our surgeons to perform the procedure you are having done.

The second charge will be the surgeon/surgery charge. The surgeon/surgery charge will come from MU Health Care Columbia Surgical Associates, as well as the office visit charge. We charge you after the procedure has been done by one of our surgeons. This charge will come after the procedure/surgery is done because we do not know exactly what will be done until our surgeon performs what is needed for you, the patient.

The third charge you may have is an anesthesiology charge. You only have this charge if you have sedation or a general anesthetic. This is not billed through us and will be billed separately.

The final charge you may have is a pathology charge. You will only have a pathology charge if you have something that needs biopsied or removed. This is not billed through us and will be billed separately.