RICHARD ELLER, MD BETH ANGLIN, MD JAMES HUDGINS, MD ALAN LONDON, MD

HISTORY AND PHYSICAL EXAMINATION

DATE ____________________ DATE OF BIRTH___________________ AGE_________

NAME____ PREFERRED NAME ______________________________

PRESENT ILLNESS *(REASON FOR THE APPOINTMENT TODAY)* ____

____

____

____

PAST MEDICAL HISTORY *(LIST ALL HOSPITALIZATIONS AND OPERATIONS)*

YEAR	OPERATIONS AND ILLNESSES

FUNCTIONAL INQUIRY *(INDICATE 'YES' OR 'NO' TO* ***ALL*** *OF THE FOLLOWING QUESTIONS)*

GASTRIC / INTESTINAL DISEASE	Y / N	KIDNEY DISEASE	Y / N	HEART DISEASE	Y / N
HIGH BLOOD PRESSURE	Y / N	DIABETES	Y / N	TUBERCULOSIS	Y / N
LUNG DISEASE	Y / N	RHEUMATIC FEVER	Y / N		

DO YOU HAVE ANY OTHER ILLNESSES NOT LISTED ABOVE: **Y / N** *(IF YES, PLEASE LIST ILLNESSES)*

____

____

ARE YOU ALLERGIC TO ANY MEDICATIONS? **Y / N** *(IF YES, PLEASE LIST MEDICATIONS)*

____

____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? **Y / N** *(IF YES, PLEASE LIST MEDICATIONS INCLUDING HERBAL)*

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____

____

PERSONAL HISTORY:

MARITAL STATUS: S M W D NUMBER OF CHILDREN: _________

DO YOU SMOKE CIGARETTES? Y / N DO YOU DRINK ALCOHOL?____________________________________

HOW MANY PER DAY?_________________________ FREQUENCY & AMOUNT?________________________________

MAY WE LEAVE MESSAGES ON YOUR PHONE REGARDING YOUR MEDICAL INFORMATION? Y / N

FAMILY HISTORY:

	AGE	CONDITION OF HEALTH OR CAUSE OF DEATH
MOTHER		
FATHER		
BROTHERS		
SISTERS		

SURGICAL SPECIALISTS OF PLANO

RICHARD ELLER, MD BETH ANGLIN, MD JAMES HUDGINS, MD ALAN LONDON, MD

PATIENT

NAME: ______________________________ DATE OF BIRTH: __________ AGE: _____ MALE ☐ FEMALE ☐

SS#: ______________________________ DL#: ____________________ S ☐ M ☐ D ☐ W ☐

ADDRESS: ______________________________ CITY: ____________________ ZIP: ______________

HOME PH #: ______________________________ CELL PH #: ______________________________

WORK PH #: ______________________ EXT. ______ PAGER: ______________________________

PATIENT'S EMPLOYER: ______________________________ OCCUPATION: ______________________

EMPLOYER ADDRESS / CITY: ____

PRIMARY CARE PHYSICIAN: ______________________________ PHONE: ______________________

REFERRING PHYSICIAN: ______________________________ PHONE: ______________________

PHARMACY: ______________________________ PHONE: ______________________

EMERGENCY CONTACT ***NOT*** LIVING WITH YOU: ______________________________________

RELATIONSHIP TO PATIENT: ______________________________ PHONE: ______________________

DO YOU HAVE HEALTH INSURANCE? **Y / N** WHO IS THE PRIMARY POLICY HOLDER? SELF / SPOUSE / PARENT / OTHER

NAME OF PRIMARY INSURANCE CO.: ____

ID#/SS#: ______________________________ GROUP #: ______________________________

DO YOU HAVE SECONDARY INSURANCE? **Y / N** WHO IS THE POLICY HOLDER? SELF / SPOUSE / PARENT / OTHER

NAME OF SECONDARY INSURANCE CO.: ____

ID#/SS#: ______________________________ GROUP #: ______________________________

POLICY HOLDER'S NAME: (***IF OTHER THAN THE PATIENT***) ______________________________

DOB: ____________________ SS#: ____________________ DL#: ____________________

EMPLOYER: ______________________________ OCCUPATION: ______________________

ADDRESS: ____

CITY/ST/ZIP: ______________________________ WK PHONE: ______________________

SPOUSE'S NAME: ______________________________ DOB: ______________________

EMPLOYER: ______________________________ WK PHONE: ______________________

I assign all medical/surgical benefits to which I am entitled to attending physician. I authorize the release of medical information necessary to request reimbursement from insurance companies. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. Due to contract language between physician and insurance company, I understand that I am financially responsible for all charges deemed to be "non-covered benefits" by my insurance company even if the insurance's Explanation of Benefits state the procedure is a "non-covered benefit" and "patient is not responsible". (If a minor, I hereby authorize the physician to treat my child as deemed medically necessary.) Non payment by the patient can result in collection fees and attorney fees.

SIGNATURE: ______________________________ **DATE:** ______________________

Notice of Privacy Practices

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.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or the payment thereof.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect a copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information, to provide you with this Notice of Privacy Practices, and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

I will allow messages to be left on my answering machine or voice mail: Y / N

Persons authorized to discuss Medical Information:

Name:______________________________ Relationship__________ Phone____________________

Name:______________________________ Relationship__________ Phone____________________

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak with the Office Manager or Privacy Officer to obtain additional information regarding any questions you may have concerning this Notice or to receive a printed copy of the Notice. This Notice of Privacy Practices is effective April 14, 2003.

Patient Name (Please Print) ____

Patient Signature____ Date __________________
(Or Legal Guardian)

PATIENT NAME: ________________________________DATE:___________________________________

PATIENT HISTORY
HAVE YOU EXPERIENCED ANY OF THE FOLLOWING RECENTLY?

CONSTITUTIONAL

Weight Gain	Y	N
Weight Loss	Y	N
Fatigue	Y	N
Weakness	Y	N
Fever	Y	N
Chills	Y	N
Night Sweats	Y	N

EYES

Unexplained Vision Problems	Y	N
Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N

EARS/NOSE/MOUTH/THROAT

Ear Pain	Y	N
Ear Discharge	Y	N
Vertigo	Y	N
Nasal Discharge	Y	N
Nasal Congestion	Y	N
Nose Bleeds	Y	N
Bleeding Gums	Y	N
Mouth Lesions	Y	N
Neck Mass	Y	N
Neck Pain	Y	N

CARDIOVASCULAR

Chest Pain	Y	N
Palpitations	Y	N
Dyspnea (shortness of breath)	Y	N
Shortness of breath when lying down	Y	N
Edema	Y	N

RESPIRATORY

Difficulty breathing	Y	N
Wheezing	Y	N
Cough	Y	N
Bloody Cough	Y	N

GASTROINTESTINAL

Abdominal Pain	Y	N
Nausea	Y	N
Vomiting	Y	N
Diarrhea	Y	N
Constipation	Y	N
Heartburn	Y	N
Difficulty Swallowing	Y	N
No Appetite	Y	N
Blood in Mouth	Y	N
Blood in Rectum	Y	N

GU

Painful Urination	Y	N
Blood in Urine	Y	N
Urinary Incontinence	Y	N

MUSCULAR/SKELETAL

Back Pain	Y	N
Bone Pain Where______________	Y	N
Joint Pain Where______________	Y	N

SKIN

Rash	Y	N
Skin Lesions	Y	N
Nail Changes	Y	N

NEUROLOGICAL

Headache	Y	N
Fainting	Y	N
Paralysis	Y	N
Weakness	Y	N
Numbness	Y	N
Pain	Y	N
Confusion	Y	N

PSYCHOLOGICAL

Severe Anxiety	Y	N
Severe Depression	Y	N
Impaired Memory	Y	N
Sleep Difficulty	Y	N

HEMATOLOGY

Easy Bleeding	Y	N
Easy Bruising	Y	N