Patient History Questionnaire

Date of Visit: ____ / ____ / _____	Last Name:	First:	Middle Initial:
	Birthday: / /	Age:	☐ Female ☐ Male
	Referring Physician:		Height:
			Weight:

What is the reason for your visit?	

Have you had any testing done for the reason of your visit?	☐ No	☐ Yes, and where was it performed _____ ☐ Ultrasound ☐ Mammogram ☐ Other _____ ☐ CT ☐ HIDA scan
Are you allergic to any drugs?	☐ No	☐ Yes, I'm allergic to:
Do you take any medications?	☐ No	☐ Yes, I take: ☐ Aspirin/Blood Thinners 1._____ 3._____ 5._____ 2._____ 4._____ 6._____
Have you ever had surgery?	☐ No	☐ Yes, I had (**please include what type of surgery and year**): 1. _____ 3. _____ 5. _____ 2. _____ 4. _____ 6. _____

Social Habits	**Marital Status**	☐ Single ☐ Married ☐ Divorced ☐ Widowed
	Exercise	☐ Never ☐ Several times/week ☐ Daily
	Tobacco Use	☐ Never ☐ I smoke ___ pack(s)/day for __ years ☐ Year Quit _____
	Alcohol Use	☐ Never ☐ Rare ☐ Once/week ☐ Daily
	Other Drugs	☐ Never ☐ I use/have used:

Are there any major illnesses (such as heart disease, diabetes, or cancers) or bleeding disorders in your family?

Please specify which family member	Mother has/had:
	Father has/had:
	Brother/Sister have/had:
	Maternal/Paternal Grandparents have/had:

Patient Statement: To the best of my knowledge, the above information is accurate and complete.

Patient Signature:	Date: / /	Reviewed by Physician:

Patient History Questionnaire: Review of Systems

Last Name:	First:	Middle Initial:

Please check the boxes below next to any illness or problems that you may have or had at one time.

General

☐ None

☐ Weight loss (more than 10lbs/month)
☐ High Blood Pressure
☐ High Cholesterol
☐ Cancer _____

Musculoskeletal

☐ None

☐ Arthritis
☐ Joint pain or swelling
☐ Neuropathy
☐ Fibromyalgia

Neurologic

☐ None

☐ Strokes
☐ Mini-Stroke
☐ TIA
☐ Brain Tumor or Aneurysm
☐ Paralysis or Seizures

Endocrine

☐ None

☐ Diabetes
☐ Thyroid Disease
☐ Cushing's or Adrenal Disease

Head/Neck

☐ None

☐ Difficulty swallowing
☐ Masses or swelling in throat or neck
☐ Exposure to neck radiation
☐ Trouble with vision

Genitourinary

☐ None

☐ Trouble urinating
☐ Blood in urine
☐ Kidney stones
☐ Kidney failure/dialysis

Heart

☐ None

Cardiologist _____

☐ Heart Attack
☐ Chest pain or angina
☐ Heart Failure
☐ Irregular Heart Beat
☐ Pacemaker
☐ Murmur
☐ Heart Catheterization (Year _____)
☐ Heart surgery (Year _____)
☐ Last stress test was: / /

Gastrointestinal

☐ None

☐ Diarrhea
☐ Nausea or Vomiting
☐ Abdominal pain
☐ Rectal Bleeding
☐ Constipation
☐ Inflammatory bowel disease
☐ Pancreatitis
☐ Hepatitis
☐ GERD/Reflux
☐ Crohn's disease
☐ Diverticulitis

Lungs

☐ None

☐ Cough or Shortness of breath
☐ Pneumonia
☐ Sleep Apnea
☐ Asthma
☐ Emphysema
☐ COPD

Vascular

☐ None

☐ Leg pain when walking or at rest
☐ Aneurysms
☐ Leg/foot ulcers or wounds
☐ Blood clots
☐ Varicose Veins

Women

Age of first menses _____
Number of pregnancies: ____/
Miscarriages _____ Abortions:_____
Age of first pregnancy _____
Last menstrual period: ___/___/_____
Sexually transmitted diseases _____

Men

☐ None

☐ Prostate problems
☐ Erectile dysfunction
☐ Testicular pain or swelling
☐ Hernias or Previous Hernia Surgery
☐ Sexually transmitted diseases _____

Patient Statement: To the best of my knowledge, the above information is accurate and complete.

Patient Signature:	Date: / /	Reviewed by Physician:

Patient Registration Form

Last Name:	First Name:	Middle Initial:
Birthday: / /	Social Security #:	☐ Female ☐ Male

Local Address					
	Street	City		State	Zip
	Home Phone #	Cell Phone #	E-mail Address		
Permanent Address (If Different from Above)					
	Street	City		State	Zip
	Home Phone #	Cell Phone #	E-mail Address		

Occupation _____ Employer _____ Phone _____

Emergency Contact Person:		Phone #:	Relationship:

Primary Insurance	Please check if being treated for an ☐ **Auto Accident** or ☐ **Worker's Compensation**		
	Insurance Company		Name of Insured Subscriber
	Subscriber's Birth Date	Subscriber's Social Security	Employer
Secondary Insurance			
	Insurance Company		Name of Insured Subscriber
	Subscriber's Birth Date	Subscriber's Social Security	Employer

Privacy act: This authorization for use and/or disclosure applies to the information described below:
Is it ok to leave a detailed message on your answering machine? ☐ Yes ☐ No
Is it ok to release information to anyone other than you? ☐ Yes ☐ No
If YES, please list each person or medical office below:

Name or MD: _____ Relationship: _____ Phone: _____

Name or MD: _____ Relationship: _____ Phone: _____

Name or MD: _____ Relationship: _____ Phone: _____

Name or MD: _____ Relationship: _____ Phone: _____

Patient Statement: I understand that I am ultimately responsible for any services NOT COVERED by my insurance company. I authorize my insurance company to pay Dr. Erbella directly for services rendered by him or his office.

Patient /Legal Guardian Signature:	Date: / /

TAMPA BAY SURGICAL GROUP

PATIENT INFORMATION

Patient Name: _____ Age: _____ Date: _____

Ethnicity: ☐ African American ☐ American Indian/Alaska Native ☐ Asian

☐ Caucasian ☐ Hispanic ☐ Other _____

Language: ☐ English ☐ Spanish ☐ Other _____

Pneumonia vaccination, if age 64 or older: list date: _____
Influenza vaccination date: _____

Screenings: ☐ Mammogram within past 2 years, list date: _____

☐ Colonoscopy within past 10 years, list date: _____

☐ Sigmoidoscopy within past 5 years, list date: _____

TAMPA BAY SURGICAL GROUP

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ DOB: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP _____

I AUTHORIZE THE USE AND/OR RELEASE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED BELOW. I UNDERSTAND THIS AUTHORIZATION IS VOLUNTARY AND IS MADE TO CONFIRM MY INSTRUCTIONS. I ALSO UNDERSTAND THAT SPECIFIC INFORMATION TO BE RELEASED MAY INCLUDE, BUT IS NOT LIMITED TO HISTORY, DIAGNOSIS, AND /OR TREATMENT OF DRUG OR ALCOHOL ABUSE, MENTAL/PSYCHIATRIC RELATED ILLNESS OR COMMUNICABLE DISEASE, INCLUDING HIV AND AIDS

INFORMATION TO BE RELEASED

☐ ENTIRE MEDICAL RECORD ☐ OFFICE NOTES ☐ PROGRESS NOTES

☐ PATHOLOGY REPORTS ☐ LAB REPORTS ☐ OTHER (SPECIFY) _____

RELEASING ORGANIZATION:

_____

_____

_____

SEND TO:

DR. JOSE ERBELLA
250 2ND STREET EAST, SUITE 1A
BRADENTON, FL 34208
T: 941.896.4788
F: 941.896.4791

SIGNATURE

I HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THE CONTENTS OF THIS AUTHORIZATION. I CONFIRM THAT THE CONTENTS ARE CONSISITENT WITH MY DIRECTION TO THE HEALTH CARE PROVIDER. I UNDERSTAND THAT, BY SIGNING THIS FORM, I AM CONFIRMING MY AUTHORIZATION THAT THE HEALTH CARE PROVIDER MAY USE AND/OR DISCLOSE TO THE PERSONS AND/OR ORGANIZATIONS NAMED IN THIS FORM. I ALSO UNDERSTAND THAT SPECIFIC INFORMATION TO BE RELEASED MAY INCLUDE, BUT IS NOT LIMITED TO HISTORY, DIAGNOSIS, AND/OR TREATMENTS OF DRUG OR ALCOHOL ABUSE, MENTAL/PSYCHIATRIC RELATED ILLNESS OR COMMUNICABLE DISEASE, INCLUDING HIV AND AIDS.

SIGNATURE OF PATIENT: _____ DATE: _____

NAME OF LEGAL GUARDIAN: _____ DATE: _____

SIGNATURE OF LEGAL GURADIAN: _____ DATE: _____

TAMPA BAY SURGICAL GROUP

FINANCIAL POLICY AND ASSIGNMENT OF BENEFITS

Patient Name _____

Thank you for choosing Tampa Bay Surgical Group/Dr. Jose Erbella as your health car provider. We are committed to providing you The best available medical care. Our staff will be pleased to discuss our fees and this policy with you at any time. We ask that all patients read and sign our financial policy and assignment of benefits as well as complete our Patient Information Form prior to seeing the physician. Payments for service are due at the time services are rendered. We accept cash, check, Visa, Discover and Mastercard. We will be happy to help you process your insurance claim for reimbursement. In special instances, we may accept assignment of insurance benefits. However, you much understand that:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance and "usual and customary" charges. We are, however, contracted with most local managed care plans. We will follow their guidelines for reimbursement and submission of claims for services rendered. Any contractual provider discounts will be deducted from your balance.
2. All charges are your responsibility-whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover, or limit your coverage by design.
3. Fees for these services, along with unpaid deductibles, and co-payments, are due at the time of service.
4. If you have a high deductible health plan, we may collect your deductible before your surgical procedure is performed.
5. If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. After all, if your insurance does not pay, you are responsible for payment.
6. If your insurance company does not pay in full within 60 days, we require you to pay the balance by cash, check, Visa, Discover or Mastercard.
7. Returned checks and balances older than 90 days are subject to collection agency placement, collection fees, and reasonable attorney's fees. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us, so that we may assist you in the management of your account.

Lifetime Authorization

I hereby assign all medical and surgical benefits allowable and otherwise payable under my current insurancy policy for services rendered and authorize and direct my insurance carrier(s) to issue payment directly to Tampa Bay Surgical Group/Dr. Jose Erbella. I understand that I am responsible for any amount not covered by insurance, including applicable co-payments, deductibles, non-covered services, and unauthorized services, and agree to pay in a current manner.

I understand that Tampa Bay Surgical Group/Dr. Jose Erbella M.D. **does accept** assignment for Medicare and payments will be directed to Tampa Bay Surgical Group.
Should my account be referred for collection procedures, I also agree to pay reasonable attorney's fees and collection expenses.

I certify that I have read and understand the above, and as the patient, guarantor, or patient's responsible party, agree to and accept these terms.

_____ _____

Signature of Patient/Responsible Party Date

_____

Print Name/Relationship