MAT-SU SURGICAL ASSOCIATES

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Patient Interview Form

Patient Information

First Name: _____ Last Name: _____

Date Of Birth: _____ Age: _____

Sex

- ☐ Male
- ☐ Female
- ☐ Other
- ☐ Unknown

Race

Select one or more

- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other Race
- ☐ Unknown
- ☐ Patient declines to specify
- ☐ Prohibited by state law

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Patient declines to specify
- ☐ Prohibited by state law
- ☐ Unknown

Preferred Language

- ☐ English
- ☐ Russian
- ☐ Spanish; Castilian
- ☐ Patient declines to specify

Allergies

- ☐ Patient has no known allergies
- ☐ Patient has no known drug allergies
- ☐ Adhesive Tape
- ☐ Aspirin
- ☐ Erythromycin
- ☐ Cephalosporins
- ☐ Penicillins
- ☐ Sulfa's
- ☐ Shellfish
- ☐ Iodine
- ☐ Latex

Other: _____

Other: _____

Current Medications

- ☐ None

Name	Dose	How taken?

Past or Present Medical Conditions

- [ ] None

- [ ] Alzheimer's Disease
- [ ] Anemia
- [ ] Anxiety Disorder
- [ ] Arthritis
- [ ] Asthma
- [ ] Atrial Fibrillation
- [ ] Barrett's Esophagus
- [ ] Bipolar Disorder
- [ ] Blood Clots (Leg)
- [ ] Blood Clots (Lung)
- [ ] Bowel Obstruction
- [ ] Celiac Disease
- [ ] Cirrhosis
- [ ] Colon Cancer
- [ ] Colon Polyp, History of
- [ ] Congestive Heart Failure
- [ ] C.O.P.D.
- [ ] Coronary Artery Disease
- [ ] Crohn's Disease
- [ ] Dementia
- [ ] Depression
- [ ] Diabetes Mellitus Insulin Dependent (Type 1)
- [ ] Diabetes Mellitus, Non-Insulin Dependent (Type 2)
- [ ] Diverticulitis
- [ ] End Stage Renal Disease
- [ ] Frailty
- [ ] Gallstones
- [ ] Gastroesophageal Reflux Disease (GERD)
- [ ] Gout
- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] Heart Attack
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Hypothyroidism
- [ ] Irritable Bowel Syndrome
- [ ] Kidney Disease
- [ ] Kidney Stones
- [ ] Oxygen Dependence
- [ ] Pancreatitis
- [ ] Parkinson's Disease
- [ ] Peptic Ulcer Disease
- [ ] Seizure Disorder
- [ ] Sleep Apnea
- [ ] Stroke
- [ ] Transient Ischemic Attack
- [ ] Ulcerative Colitis
- [ ] Vascular Disease
- [ ] Wheel Chair Bound

- [ ] Other: _____
- [ ] Other: _____

Previous Procedures

- [ ] None

- [ ] Abdominal aortic aneurysm (AAA) repair — When: _____
- [ ] Appendectomy — When: _____
- [ ] Bilateral Tubal Ligation (BTL) — When: _____
- [ ] Cardiac Cath -with stent placement — When: _____
- [ ] Colon Resection — When: _____
- [ ] Coronary Artery Bypass Graft (CABG) — When: _____
- [ ] Defibrillator Placement — When: _____
- [ ] Exploratory Laparoscopy — When: _____
- [ ] Fundoplication -Nissen — When: _____
- [ ] Gallbladder Removed — When: _____
- [ ] Gastric Bypass — When: _____
- [ ] Gastric Lap Band — When: _____
- [ ] Heart Valve Replacement — When: _____
- [ ] Hemorrhoidectomy — When: _____
- [ ] Hiatal Hernia Repair — When: _____
- [ ] Hernia Repair - Inguinal — When: _____
- [ ] Hernia Repair - Umbilical — When: _____
- [ ] Hernia Repair - Abdominal Wall — When: _____
- [ ] Hysterectomy - Abdominal — When: _____
- [ ] Joint Replacement Specify Site — When: _____
- [ ] Lung Lobectomy — When: _____
- [ ] Lumpectomy, Breast — When: _____
- [ ] Mastectomy Left — When: _____
- [ ] Mastectomy Right — When: _____
- [ ] Small Bowel Resection — When: _____
- [ ] Vasectomy — When: _____
- [ ] Other: _____ — When: _____
- [ ] Other: _____ — When: _____

Diagnostic Studies/Tests

- [ ] None

- [ ] Blood Tests — When: _____
- [ ] Colonoscopy — When: _____
- [ ] CT Abd/Pelvis — When: _____
- [ ] CT Chest — When: _____
- [ ] EGD — When: _____
- [ ] ERCP — When: _____
- [ ] MRI Abd/Pelvis — When: _____
- [ ] PET Scan — When: _____
- [ ] Ultrasound Abd/Pelvis — When: _____
- [ ] Other: _____ — When: _____
- [ ] Other: _____ — When: _____

Social History

Alcohol ☐ None

Type	Quantity	Number	Frequency
☐ Beer			
☐ Wine			
☐ Hard Liquor			

Tobacco

Smoking Status ☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoker

☐ Smoker, current status unknown ☐ Light tobacco smoker ☐ Heavy tobacco smoker ☐ Unknown if ever smoked

Type	Started	Quit	Quantity	Frequency
☐ Cigarettes				
☐ Cigar				
☐ Chewing Tobacco				

Drug Use

☐ None

Type	Quantity	Number	Frequency
☐ Recreational			Times / month
☐ Street Drugs			
☐ Medications Not Prescribed to You			
☐ Marijuana			

Family Medical History

☐ No knowledge of family history

☐ **No family history of** Colon Cancer

	Mother	Father	Brother	Sister	Son	Daughter
Health Status						
Alive	○	○	○	○	○	○
Deceased/At Age	○ ____	○ ____	○ ____	○ ____	○ ____	○ ____
Cause of Death	____	____	____	____	____	____
Diagnoses						
Colon cancer	○	○	○	○	○	○
Rectal cancer	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○
Barrett's esophagus	○	○	○	○	○	○
Esophageal cancer	○	○	○	○	○	○
Breast cancer	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○
Heart disease	○	○	○	○	○	○
Hypertension	○	○	○	○	○	○
Lung cancer	○	○	○	○	○	○
Malignant hyperthermia	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○
Other:	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic	Y	N
strong allergic reactions or urticaria	○	○

Cardiovascular	Y	N
Chest Pain	○	○
Difficulty Climbing Stairs	○	○
Chest Pain with Activity	○	○
Short of Breath - Exertion	○	○

Constitutional	Y	N
Fatigue	○	○
fever	○	○
Chills	○	○

ENMT	Y	N
Sore Throat	○	○
Runny Nose	○	○
Throat Tenderness	○	○
Thyroid Troubles or Mass	○	○

Endocrine	Y	N
Increased Thirst	○	○
Increased Hunger	○	○
Weight Gain	○	○
Weight Loss	○	○

Eyes	Y	N
Blurry Vision	○	○
Vision Changes	○	○

Gastrointestinal	Y	N
Abdominal Pain	○	○
Change in Bowel Habits	○	○
Constipation	○	○
Diarrhea	○	○
Heartburn	○	○
Nausea	○	○
Vomiting	○	○
Black Tarry Stools	○	○
Blood in Stool	○	○
Hernias	○	○
Swallowing Problems	○	○

Genitourinary	Y	N
Frequent Urination	○	○
urethral discharge or incontinence	○	○
Trouble Urinating	○	○

Hematologic/Lymphatic	Y	N
Anemia	○	○
Bleeding Easily	○	○
Transfusion Reaction	○	○

Integumentary	Y	N
Itching	○	○
Rashes	○	○

Musculoskeletal	Y	N
Joint Pain	○	○
Muscle Pain	○	○

Neurological	Y	N
Headaches	○	○
Seizures	○	○

Psychiatric	Y	N
Anxiety	○	○
Depression	○	○
Suicidal Thoughts	○	○

Respiratory	Y	N
Cough	○	○
Breathing Problems	○	○

Immunizations

○ None

○ Flu vaccine ○ Pneumonia vaccine

When:____/___/____ When:_____

Month/ Day /Year Year

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

○ Yes ○ No

X

Patient Signature/Responsible Party **Date**

Completed by/Reviewed with

○ Patient ○ Parent ○ Guardian ○ Not Present

MAT-SU SURGICAL ASSOCIATES

FIRST NAME _____ MI _____ LAST NAME _____

PREFERRED NAME _____ DATE OF BIRTH _____ SEX: (circle) MALE FEMALE

MAILING ADDRESS_____ CITY _____ STATE _____ ZIP _____

SS # _____ E-MAIL _____ MARITAL STATUS: (circle) M S W D

HOME PHONE_____ WORK PHONE_____ CELL PHONE _____

RACE: _____ETHNICITY: _____ PREFERRED LANGUAGE: _____

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

PRIMARY INSURANCE_____ POLICY # _____ GROUP #_____

SUBSCRIBER NAME _____ DOB _____

SECONDARY INSURANCE_____ POLICY # _____ GROUP # _____

SUBSCRIBER NAME _____ DOB _____

PHARMACY_____

EMERGENCY CONTACT AND CONSENT TO DISCLOSE HEALTH INFORMATION

We respect your right to privacy regarding medical information. Please list the names of individuals with whom we may share information, including the type of information, without additional written consent.

Name _____ Relationship _____ Contact Number _____

☐ Emergency Contact ☐ Medical Health Information ☐ Billing Information

Name _____ Relationship _____ Contact Number _____

☐ Emergency Contact ☐ Medical Health Information ☐ Billing Information

May we leave a confidential message on your voice mail: YES NO

BENEFIT ASSIGNMENT / ACKNOWLEDGEMENT OF PRIVACY PRACTICES

_____ (Initial) I certify that the above insurance and demographic information is true and correct to the best of my knowledge. I authorize Garth LeCheminant, MD, David Morrow, MD, FACS, or Jennifer Lemert, NP, to administer medical treatment. The office has my permission to obtain or release medical records from outside sources that may be important for the continuation of my care (or in the best interest of my dependent if I am signing as a parent or guardian).

_____ (Initial) I understand that I have the right to receive and review a written description of how this practice will handle health information about me. This is known as a Notice of Privacy Practices and describes the use and disclosure of health information made and the information practices followed by the employees, staff, and other office personnel of the Providers, and my rights regarding my health information. The current version of the Notice of Privacy Practices is posted in the waiting/reception area and on our website @ matsusurgical.com.

_____ (Initial) I authorize payment of medical benefits to Mat-Su Surgical Associates. I understand that I am financially responsible for all charges, even if not paid by insurance. I authorize the release of any information necessary to secure the payment of benefits. I agree that all charges for medical services rendered that are not directly paid by my insurance will be my responsibility.

x _____

Patient Signature/Responsible Party **Date**

MAT-SU SURGICAL ASSOCIATES

FINANCIAL POLICY

Thank you for choosing Mat-Su Surgical Associates for your healthcare needs. We are committed to providing you the best surgical healthcare available. You are required to read and sign our financial policy prior to any treatment. Please feel free to ask any questions. A copy of this policy will be provided to you upon request.

_____ (Initial) INSURANCE - As a courtesy to our patients, we bill and participate with most insurance types. It is your responsibility to know your insurance benefits. If you are unsure of your benefits, please contact your insurance carrier with questions. If you do not provide proof of insurance, you will be expected to pay in full at the time of service or make payment arrangements with our billing staff. You will be considered a self-pay patient until the insurance information is provided to our office.

- **PROOF OF INSURANCE –**We must obtain a copy of your insurance card(s) and a copy of a photo ID for billing. Failure to provide us with the correct information will result in the inability to assist you in filing insurance claims.
- **CLAIM SUBMISSION –**As a courtesy to our patients, we will submit claims. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their requests.
- **CO-PAYMENT/CO-INSURANCE/DEDUCTIBLE** – Co-pays are due at time of service. Co-pays, co-insurance, and deductibles are part of your contractual obligation with your insurance company and are patient responsibility.
- **SCREENING COLONOSCOPY-** Prior to scheduling a screening colonoscopy, you will have a pre-op exam in the office. The office exam is NOT part of the procedure and will be billed to your insurance carrier. This office visit may be subject to your deductible or co-insurance depending on your insurance plan.
- **NON-COVERED SERVICES** – Please be aware that some or all of the services provided may not be covered or not considered reasonable or necessary by some insurers. It will be your responsibility to pay for these services.
- **CHANGE IN COVERAGE** - If your insurance coverage changes, please notify us as soon as possible, so we can make the appropriate changes to help you receive your maximum benefits.
- **USUAL AND CUSTOMARY –** Our prices are representative of the usual and customary charges for our geographic area. You are expected to pay in full for any balance after insurance.

_____ (Initial) NON-PAYMENT – If your account is thirty days past due, you may be contacted by our billing department asking for payment in full or to make payment arrangements. If your balance is unpaid after three months, we may refer your account to Cornerstone Credit Services, a collection agency.

_____ (Initial) CREDIT BALANCE – A refund will be generated to the responsible party if an account has a credit balance over $10.00. Balances less than $10.00 will be retained and applied to future balances unless a refund is specifically requested.

_____ (Initial) NO SHOW POLICY – any patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least a 24-hour notice will be considered a 'No Show' and charged a $75.00 fee.

_____(Initial) SELF-PAY ACCOUNTS – You are required to bring a minimum of $200 toward the initial office visit. If the total balance due is more than you are able to pay at time of service, reasonable payment arrangements may be made by signing a self-pay financial agreement.

I acknowledge that I have read and agree to the above Financial Policy.

X

Patient Signature/Responsible Party **Date**