Pulaski Surgery Clinic, P.A.* 3401 Springhill Drive, Ste 400* North Little Rock, AR 72117* (501) 945-4422 phone * (501) 9454424 fax

# PATIENT INFORMATION (PLEASE **PRINT**)

Dr. Stair / Dr. DeLoach/ Dr. Hayes/ Dr. Bevans III/ Dr. Shaw (Please circle which doctor you are seeing)

**Patient's Name** ________________________________________ **Date of Birth** ____________________ **Age**_____________

**Address**______________________________________________**City** ______________________ **State** ______ **Zip**___________

**Home Phone**__________________________________________**Cell Phone**_________________**SS#**______________________

**E-mail address**____________________________________________________________________________________________

**Sex**_____**Race** _______ **Ethnicity** _________ **Marital Status** ________ **Referring Physician**__________________________

**Employer**____________________________________________**Phone**_______________________________**Ext** ____________

**Employer Address**_____________________________________**City** ______________________ **State** _____ **Zip**____________

**Spouse's Name (or Parent's name if Minor)**____________________________________________**SS#** ______________________

**Spouse's/ Parent's Employer** ____________________________ **Phone**_______________________________**Ext** _____________

**Next of Kin, Not in the same household** ______________________________ **Phone** ___________________________________

**Address** _______________________________________________ **City** _____________________ **State**_____ **Zip**_____________

**Emergency Contact** _____________________________________________ **Phone** _____________________________________

Have you ever been seen by any of our doctors? If yes, which doctor? __________________________________________
Please state when and where:____________________________________________________________________________

ARE YOU BEING SEEN FOR A WORK RELATED INJURY? **YES NO** DATE OF INJURY:___________________________
WAS YOUR EMPLOYER NOTIFIED? **YES NO**

**Primary Care Physician**_______________________________________________________________________

** PRIMARY INSURANCE___________________________________________________________________________
Address_____________________________________________________ City ___________________ State _____Zip ____
Subscriber Name____________________________ Date of Birth ________________
ID # ________________________________________ / Group# ______________________________________________

** SECONDARY INSURANCE________________________________________________________________________
Address_____________________________________________________ City ___________________ State _____Zip ____
Subscriber Name____________________________ Date of Birth ________________
ID # _______________________________________ / Group#___________________________________________________

I authorize release of any medical information necessary to process all insurance claims. I understand and acknowledge primary responsibility for the medical fees not covered by insurance. I hereby authorize payment directly to the above named physician of the group insurance benefits otherwise payable to me. I also authorize release of medical records from North Metro Medical, Baptist Health, St. Vincent, North River Surgery and Springhill Surgery Center.
(Signatures of patient if minor, parent or guardian please sign.)

Signed: ___________________________________________________________________Date_______________________

## Medicare Authorization Only

I request that payment of authorize Medicare benefits be made either to me or on my behalf to Drs. Stair, DeLoach, Hayes, Bevans III or Shaw

Signed:_______________________________________________________________ Date__________________

**PULASKI SURGERY CLINIC**
**FINANCIAL RESPONSIBILITY AGREEMENT**

Thank you for choosing Pulaski Surgery Clinic (“PSC”). We are committed to providing you with quality and affordable health care. Our practice financial policy is as follows:

**1. Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is required at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit may be required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Contact your insurance company directly for any questions regarding your coverage. By signing this form you authorize PSC to release the necessary information in order to complete and process your insurance claims.

**2. Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. **This arrangement is part of your contract with your insurance company.**

**3. Non-covered services.** By signing this agreement, you understand that some, and perhaps all, of the services you receive may not be covered by your insurance or not considered reasonable or necessary by Medicare or other insurers. You agree to pay for any services which have been determined by your insurance plan to be “non-covered”. Payment in full for these services is generally due at each visit.

**4. Updates.** Our staff will ask you to verify your billing information at each and every visit. Current information is essential in order for us to contact you regarding your treatment and for obtaining timely payment from your insurance company.

**5. Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply in a timely manner with their request. Please be aware that the balance of your claim is your responsibility, whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

**6. Coverage changes.** If your insurance changes, please notify us as soon as possible so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will be billed to you.

**7. Nonpayment.** If the account is not **paid in full** after two monthly statements or a suitable payment arrangement has not been established, the account will be reported for collections.

**8. Missed appointments and Late Arrivals.** You will be charged $25 for a missed appointment if you do not notify us at least 24 hours prior to your scheduled appointment time or if you are more than 15 minutes late for your scheduled appointment. Help us to serve you better by keeping your regularly scheduled appointment and arriving at least 20-30 minutes prior to your scheduled appointment time.

**9. Returned checks (NSF).** You will be charged a $25 processing fee for any personal check returned for nonpayment.

**10. Workman’s Compensation.** If you were injured at work and have reported the injury to your employer, you must provide our office with the following information: Date of injury, Claim number, Insurance Company with address and phone number, and Adjusters name, phone and fax. If you do not have the above information, you will be required to provide your own insurance information until workman’s compensation information is provided. If you are not insured, you will be considered self-pay.

**11. Automobile Accident.** If you were injured in an automobile accident, you must provide an open claim number from your insurance company. If your claim includes attorney representation, we require a Letter of Protection from your attorney ensuring payment to our office for services rendered. You will be responsible for all unpaid balances at the time of service.

**12. Forms.** All forms requiring completion by our medical staff and/or providers will be subject to a $20 form completion fee per set.

I have read and understand the payment policy and agree to abide by its guidelines:

________________________________________ ______________________________

Signature of patient or responsible party Date

# Pulaski Surgery Clinic, P.A.

**3401 SPRINGHILL DRIVE, SUITE 400**
**NORTH LITTLE ROCK, AR 72117**

## Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Care Operations

I understand that as part of my health care, this organization originates and maintains health records describing my demographic information, health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means to provide for reimbursement from my health insurance company, with transmission of necessary health information via electronic media
- a means by which a third-party payer can verify that services billed were actually provided
- a source of information for consideration of inclusion in clinical research studies
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand that I may receive artificial, prerecorded, or automated calls and or/texts from Pulaski Surgery Clinic.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that the organization is not required to agree to the restrictions requested. I understand that this consent may be revoked with a written notice from me or my legal representative. The revocation will not apply to any past disclosures (for the purposes of treatment, payment, health care operations, clinical research activity, or other mandatory disclosures) that the organization has already disclosed based on my previous consent.

☐ I request the following restrictions to the use or disclosure of my health information.

________________________________________________________

We will not discuss any aspect of your protected health information with anyone other than yourself without your written consent. If you wish for us to share any of your health information with persons (other than yourself), please list them below and their relationship to you:

____________________________ ____________________________
Name Relationship to Patient

**I have received a copy of the *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I have been given the right to review the notice prior to signing this consent. I understand that this clinic reserves the right to change their notice and practices. I may call the clinic at any time to request a current copy of the privacy practices.**

____________________________ ____________________________
**Name (Printed)** **Date**

____________________________ ____________________________
**Signature of Patient or Legal Representative** **Authority to Consent**

____________________________ ____________________________
*Witness (Pulaski Surgery, P.A. Staff)* *Date*

Approved: April 2003 Revision: March 2014

# Medications List

**Patient Name:** ____________________________________________

**Are you currently on any blood thinners? Yes or No**

**Are you currently on any arthritis medications? Yes or No**

**Please list all other medications you are currently taking:** (Include dosage and frequency)

| Arthritis Medications: | Dosage | Frequency |
|---|---|---|
| ☐ Aleve | ______ | ________ |
| ☐ Ibuprofen | ______ | ________ |
| ☐ Naprosyn | ______ | ________ |
| ☐ Mobic (Meloxicam) | ______ | ________ |
| ☐ Other ____________ | ______ | ________ |

| Blood Pressure Medication: | Dosage | Frequency |
|---|---|---|
| ☐ Atenolol (Tenormin) | ______ | ________ |
| ☐ Diltiazem (Carizem) | ______ | ________ |
| ☐ Lisinopril (Zestril) | ______ | ________ |
| ☐ Metoprolol (Lopressor) | ______ | ________ |
| ☐ Other ____________ | ______ | ________ |

| Blood Thinners: | Dosage | Frequency |
|---|---|---|
| ☐ Aggrenox (Aspirin) | ______ | ________ |
| ☐ Aspirin | ______ | ________ |
| ☐ Coumadin (Warfarin) | ______ | ________ |
| ☐ Eliquis (Apixaban) | ______ | ________ |
| ☐ Plavix (Clopidogrel) | ______ | ________ |
| ☐ Pradaxa (Dabigatran) | ______ | ________ |
| ☐ Xarelto (Rivaroxaban) | ______ | ________ |
| ☐ Other ____________ | ______ | ________ |

| Chemotherapy: | Dosage | Frequency |
|---|---|---|
| ☐ Arimidex (Anastrozole) | ______ | ________ |
| ☐ Avastin (Bevacizumab) | ______ | ________ |
| ☐ Methotrexate (Trexall) | ______ | ________ |
| ☐ Other ____________ | ______ | ________ |

| Cholesterol: | Dosage | Frequency |
|---|---|---|
| ☐ Atorvastatin (Lipitor) | ______ | ________ |
| ☐ Crestor (Rosuvastatin) | ______ | ________ |
| ☐ Pravastatin (Pravachol) | ______ | ________ |
| ☐ Simvastatin (Zocor) | ______ | ________ |
| ☐ Other ____________ | ______ | ________ |

| Diabetes Medications: | Dosage | Frequency |
|---|---|---|
| ☐ Metformin (Glucophage) | ______ | ________ |
| ☐ Glipizide (Glucotrol) | ______ | ________ |
| ☐ Insulin | ______ | ________ |
| ☐ Other ____________ | ______ | ________ |

| Diuretics: | Dosage | Frequency |
|---|---|---|
| ☐ HCTZ (Microzide) | ______ | ________ |
| ☐ Lasix (Furosemide) | ______ | ________ |

| Reflux Medications: | Dosage | Frequency |
|---|---|---|
| ☐ Prevacid | ______ | ________ |
| ☐ Prilosec | ______ | ________ |
| ☐ Other ____________ | ______ | ________ |

| Pain Medications: | Dosage | Frequency |
|---|---|---|
| ☐ Demerol (Meperidine) | ______ | ________ |
| ☐ Dilaudid (Hydromorphone) | ______ | ________ |
| ☐ Hydrocodone (Lorcet, Vicodin) | ______ | ________ |
| ☐ Oxycodone (Percocet) | ______ | ________ |
| ☐ Other ____________ | ______ | ________ |

| Other Medications: | Dosage | Frequency |
|---|---|---|
| ☐ Prednisone (Deltasone) | ______ | ________ |
| ☐ Birth Control Pills | ______ | ________ |

| Other Medications: | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Pulaski Surgery Clinic History Form**

Dr. J. Michael Stair, Dr. John DeLoach, Dr. John Hayes, Dr. David Bevans III, Dr. R. Haley Shaw

Patient Name________________________________ Age _________

Reason for Visit________________________________________________________________________________

Pharmacy Name and Location: ____________________________________________________________________

Referring Doctor_____________________________ Primary Care Physician________________________________

Cardiologist__________________________________ Gastroenterologist___________________________________

Hematologist/Oncologist______________________ Rheumatologist ______________________________________

**Patient's Medical History:** (Please check all that apply)

| | | | | | |
|---|---|---|---|---|---|
| Heart Disease | ☐ | Blood Clots in Lungs | ☐ | Hyperthyroidism | ☐ |
| High Blood Pressure | ☐ | Blood Clots in Legs | ☐ | Hypothyroidism | ☐ |
| Diabetes | ☐ | Ulcers | ☐ | Kidney Disease | ☐ |
| Asthma | ☐ | Depression | ☐ | Liver Disease | ☐ |
| Emphysema | ☐ | Bipolar Disorder | ☐ | Hepatitis | ☐ |
| Stroke | ☐ | COPD | ☐ | HIV | ☐ |
| Cancer Type__________________ | ☐ | Coronary Artery Disease | ☐ | Bleeding Problems | ☐ |
| Seizures/Epilepsy | ☐ | Diverticulitis | ☐ | Other ______________ | ☐ |
| High Cholesterol | ☐ | GERD/Reflux | ☐ | | |

**Have you ever *had* any of the following surgeries done in the past:** (Please check all that apply)

| | | | | | |
|---|---|---|---|---|---|
| Heart Bypass | ☐ | Hernia | ☐ | Knee Surgery | ☐ |
| Appendectomy | ☐ | Ovaries Removed | ☐ | Hip Surgery | ☐ |
| If yes, was appendectomy: | | Hysterectomy | ☐ | Blood Vessel Surgery | ☐ |
| OPEN or LAPAROSCOPICC | | Gallbladder | ☐ | Breast | ☐ |
| Tonsils/Adenoids | ☐ | Gastric Bypass | ☐ | Other ______________ | ☐ |

***Do you have any metal in your body? YES or NO*** ***Have you had any problems with anesthesia? YES or NO***

***Do you have a pacemaker? YES or NO***

**List Allergies:** ______________________________________________________________________________

Are you allergic to: Latex_______ Iodine________ IVP Dye_______

**Social History:**

Marital Status: Married ____ Single ________ Widowed ____ Divorced ___ Other ________

Occupation : ____________________________________________________________________________________

Do you do any heavy lifting? **YES or NO**

Smoking Status: **Never** **Former(Length/Quit____________** **Current Every Day** **Current Some Day**

Smoking: How Much:_____ Packs Per Week ________________ Packs Per Day ______________________

Do you drink alcohol? **YES or NO** If **YES**, amount per day/week________

Deaf or serious difficulty hearing? **YES or NO**

Blind or serious difficulty seeing? **YES or NO**

Difficulty concentrating, remembering, or making decisions? **YES or NO**

Difficulty walking or climbing stairs? **YES or NO**

Difficulty dressing or bathing? **YES or NO**

Difficulty doing errands alone? **YES or NO**

**Family Medical History:**

| | Deceased | Heart Disease | Cancer/Type | High B/P | Diabetes | Other (List) |
|---|---|---|---|---|---|---|
| **Mother** | | | | | | |
| **Father** | | | | | | |
| ______________________ | | | | | | |

**Patient Name:**___________________________________________________________________________

**Please give the most recent date and location of the following:**

Stomach Scope (EGD)___________________ Date_________ Colonoscopy_________________________ Date __________
Mammogram___________________________ Date _______ TB Skin Test _________________________ Date __________
CT/Ultrasound/Diagnostic Xrays _______________________________________________________________ Date___________

**Please check if you are currently having any of the following signs or symptoms:**

**General:**
______Weight Loss _____lbs.
______Weight Gain _____lbs.
______Fever
______Fatigue
_____Night Sweats

**Skin:**
______Rash
______Sores
______Itching
______Change in hair/nails

**Head/Ears/Eyes/Nose/Throat:**
______History of head or neck trauma
______Sore Throat
______Hoarseness
______Sinus Problems
______Earaches

**Breast:**
______History of breast lumps or masses
______Fibrocystic breast disease
______Nipple Discharge
______Nipple Inversion
______Pain in breast

**Respiratory:**
______Cough
______Shortness of Breath
______Wheezing
______History of TB
______Sleep Apnea

**Cardiovascular:**
______Heart palpitations/irregular heart beat
______Chest pain
______Heart murmur
______Swelling in feet
Last cardiac evaluation______________________

**Gastrointestinal:**
______Abdominal Pain
______Nausea
______Vomiting
______Diarrhea
______Constipation
______Bloody Stools
______Dark/Black Stools
______Difficulty swallowing
______Hemorrhoids

**Genitourinary:**
______Difficulty urinating
______Pain with urinations
______Inability to hold urine
______Blood in urine
______Urinary frequency
How many pregnancies? _____________
How many children? ________________
Any miscarriages? __________________
Last pap smear/Dr. __________________
Last prostate exam/Dr. _______________

**Musculoskeletal:**
______Rheumatoid arthritis
______Osteoarthritis
______Joint Pain
______Use cane/___walker/___wheelchair
______Pain in legs with walking ____blocks

**Neurological:**
______Tremors
______Headache/______Migraines
______Seizures _______Last One
______Dizziness

**Patient Signature:** ____________________________________________________________________

**Date:**________________________________________________________________________________