Patient Registration Form

Patient Name: _____Social Security # _____

Date of Birth: _____/_____/_____ Sex: M / F Marital Status: Single / Married / Divorced / Widowed

Address: _____

(Street) (City/State/Zip)

Home phone: _____ Mobile: _____ Work: _____

Email Address: _____ Would you like to be set up on our Patient Portal? Y / N

Employment: ___Full Time ___Part time ___Self ___Retired ___Student ___Unemployed

Employer: _____

Who to call for an emergency:

Name: _____ Address: _____

Phone Number: _____Relationship: _____

FIRST INSURANCE INFORMATION:

Plan Name: _____ Address: _____

I.D. Number _____ Group Number: _____

Policy Holder: _____ DOB: ____/____/_____ SS #: _____

SECOND INSURANCE INFORMATION:

Plan Name: _____ Address: _____

I.D. Number _____ Group Number: _____

Policy Holder: _____ DOB: ____/____/_____ SS #: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

The Providers at Surgical Associates of Myrtle Beach use an electronic medical record system that allows electronic prescribing of medications. Medications are sent to your pharmacy through a secure electronic prescription connection (Rx Hub) which improves the timely and accurate transmission of your medication information. To optimize the use of this electronic capability, and coordinate your care between us and other specialists, we ask that patients to allow us to access their medication history through the Rx Hub

☐ Consent to allow my provider to access ALL of my medication history.

☐ **DO NOT** consent to my provider accessing any of my medication history.

Referring Physician: _____ Primary Care Doctor: _____

Reason For Visit:

_____

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1. I authorize the release of any medical information necessary to process claims to my insurance company and medical providers/facility, and request payment to Surgical Assoc. of MB. I acknowledge that I am financially responsible for payment whether covered by insurance or not. _____
2. I authorize the receipt of my medical records to Surgical Assoc. of MB from other medical providers/facilities. _____
3. I have read and understand the financial policy of Surgical Assoc. of MB and wish to have services provided to me. _____
4. I understand that if I NO SHOW to ANY appointment that there will be a $50.00 charge to my account. _____

*****PLEASE INITIAL EACH LINE ABOVE*****

Signature of patient/Responsible Party_____ Date _____

Medical History Form

Patient Name: _____ DOB: _____/_____/_____

Personal History:

Height _____ Weight: _____

Do you Smoke? Yes No If so, how much per day? _____

Do you drink alcohol? Yes No If so, how much per day? _____

Do you drink coffee, tea, soda? Yes No If so, how much per day? _____

Current Medications & Dosages/ **If none, check here** ☐ (you may attach a list)

Medication	**Dosage**	**Frequency**

Allergies to Medications/ **If none, check ☐re**

_____

_____

_____

Previous Surgeries/ **If none, check ☐re**

_____

_____

_____

_____

_____

Please **CIRCLE** any that apply:

Eye Problems: Glasses Contacts Cataracts Glaucoma Recent Vision Changes

Ear Problems: Hard of Hearing Hearing aid Ringing in ears Ear Pain

Neck Problems: Neck pain Lumps or swelling of neck

Neurological: Seizures Stroke/TIA Frequent severe headaches Neuropathy

Skin disorders: Current open wounds Rash Cellulitis/abscess Other_____

Respiratory: Asthma Bronchitis COPD/Emphysema

Cardiac: Heart attack Heart disease Irregular heart beat Hypertension Congestive heart failure Defibrillator

Swelling of ankles and/or feet Heart murmur Pacemaker Valve replacement High cholesterol Arrhythmia

Gastrointestinal: Hiatal hernia Gallbladder disease Ulcer Crohn's disease Irritable bowel Reflux

Weight gain/loss Blood in stool Appendix removed Colon removed Diverticulitis/osis

Genitourinary: Kidney disease Kidney stones Kidney infection Prostate problems

Peripheral vascular: Leg pain when walking Cold, numb feet Change in foot color Varicose veins Aneurysm Carotid bruits

Blood, Lymph, Liver Disease: Hepatitis Cirrhosis Clotting disorder Jaundice Lymphedema Organ Transplant

Psyche: Mental illness Depression

Endocrine: Diabetes Thyroid disease Lupus

Cancer: Colon/Rectal Uterine Ovarian Breast Prostate Kidney

Other _____

Musculoskeletal: Joint replacement, if so what? _____ Back problems

Rheumatoid arthritis Osteoarthritis Fibromyalgia

Family History:

CONDITION	RELATIONSHIP TO YOU	ALIVE/DECEASED
Alcoholism		
Bleeds easily		
Colon cancer		
Ovarian cancer		
Breast cancer		
Diabetes		
Hypertension		
Heart Disease		
Stroke		
PVD		
Diverticulitis/osis		
Other :		

Signature of patient/Responsible Party_____ Date _____