

# STAT SURGICAL

8715 Village Drive Ste. 608

San Antonio, TX 78217

Phone (210) 657-2100 Fax (210) 657-2110

## PATIENT INFORMATION

Date \_\_\_\_\_ Patient Name \_\_\_\_\_

Social Security Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Work Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Patient Employer \_\_\_\_\_

Employer Phone \_\_\_\_\_

Employer Address \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Social Security Number \_\_\_\_\_

Phone \_\_\_\_\_ DOB \_\_\_\_\_

Employer \_\_\_\_\_

## IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Cell \_\_\_\_\_

Address \_\_\_\_\_

Employer \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Cell \_\_\_\_\_

Address \_\_\_\_\_

## INSURANCE INFORMATION

Subscribers Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Group # \_\_\_\_\_ ID # \_\_\_\_\_

Insurance Company \_\_\_\_\_

### INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage and assign directly to Donald Dilworth M.D., P.A. or Edward Horvath, D.O., P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

### MEDICARE

I request that payment of authorization Medicare benefits to be made either to me or on my behalf to

\_\_\_\_\_  
Name of Doctor or Clinic

For any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature \_\_\_\_\_

Printed name \_\_\_\_\_

Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Referring Physician \_\_\_\_\_

Phone Number \_\_\_\_\_

Other Physicians \_\_\_\_\_

Family Physician \_\_\_\_\_

Phone Number \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HEALTH HISTORY****STAT SURGICAL**

Check symptoms currently have or have had in the last year:

Check diseases you currently have or have had in the past:

|  |  |
|--|--|
| <p><b>General</b></p> <input type="checkbox"/> Chills<br><input type="checkbox"/> Depression/Nervousness<br><input type="checkbox"/> Dizziness/Fainting<br><input type="checkbox"/> Headache<br><input type="checkbox"/> Loss of weight<br><input type="checkbox"/> Numbness<br><input type="checkbox"/> Sweats  | <p><b>Ear, Eye, Nose, Throat</b></p> <input type="checkbox"/> Blurred Vision<br><input type="checkbox"/> Difficulty Swallowing<br><input type="checkbox"/> Hoarseness<br><input type="checkbox"/> Nosebleeds<br><input type="checkbox"/> Persistent Cough<br><input type="checkbox"/> Sinus Problems               |
| <p><b>Muscle/Joint/Bone</b></p> <input type="checkbox"/> Arms <input type="checkbox"/> Legs<br><input type="checkbox"/> Back <input type="checkbox"/> Neck<br><input type="checkbox"/> Feet <input type="checkbox"/> Hands   | <p><b>Skin</b></p> <input type="checkbox"/> Bruise Easily<br><input type="checkbox"/> Itching/Rash<br><input type="checkbox"/> Change in Moles<br><input type="checkbox"/> Scars   |
| <p><b>Genito-Urinary</b></p> <input type="checkbox"/> Blood in urine<br><input type="checkbox"/> Frequent urination<br><input type="checkbox"/> Lack of bladder control<br><input type="checkbox"/> Painful urination  | <p><b>Women Only</b></p> <input type="checkbox"/> Abnormal Pap Smear<br><input type="checkbox"/> Breast Lump<br><input type="checkbox"/> Extreme Menstrual Pain<br><input type="checkbox"/> Nipple Discharge<br><input type="checkbox"/> Vaginal Discharge<br><input type="checkbox"/> Hormone Replacement Therapy |
| <p><b>Gastrointestinal</b></p> <input type="checkbox"/> Appetite poor<br><input type="checkbox"/> Bloating<br><input type="checkbox"/> Constipation<br><input type="checkbox"/> Diarrhea<br><input type="checkbox"/> Hemorrhoids<br><input type="checkbox"/> Indigestion<br><input type="checkbox"/> Nausea<br><input type="checkbox"/> Rectal bleeding<br><input type="checkbox"/> Stomach pain<br><input type="checkbox"/> Vomiting/Vomiting Blood | <p>Age of first Period _____</p> <p>Date of last menstrual period _____</p> <p>Age of Menopause _____</p> <p>Are you pregnant? _____</p> <p>Number of children _____</p>   |

|  |  |
|--|--|
| <input type="checkbox"/> Aids/HIV<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Bleeding Disorders<br><input type="checkbox"/> Breast Lump<br><input type="checkbox"/> Cancer<br>Type _____<br><input type="checkbox"/> Cataracts<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Emphysema/COPD<br><input type="checkbox"/> Epilepsy<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Esophageal Reflux (GERD) | <input type="checkbox"/> High Cholesterol<br><input type="checkbox"/> Kidney Disease<br><input type="checkbox"/> Liver Disease<br><input type="checkbox"/> Pacemaker<br><input type="checkbox"/> Pneumonia<br><input type="checkbox"/> Rheumatic Fever<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Thyroid Problems<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Ulcers<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Heart Attack/ Disease<br><input type="checkbox"/> Venous Clots (DVT) |
| Other _____  |  |

**FAMILY MEDICAL HISTORY**

|               |                          |
|---------------|--------------------------|
|               | <b>Healthy</b>           |
| Mother _____  | <input type="checkbox"/> |
| Father _____  | <input type="checkbox"/> |
| Sister _____  | <input type="checkbox"/> |
| Brother _____ | <input type="checkbox"/> |

**SURGICAL HISTORY**

|       |       |
|-------|-------|
|       | Year  |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**MEDICATIONS** List any Medications you are currently taking

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ALLERGIES**

None Known

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SOCIAL HISTORY**

Yes No

Alcohol Use \_\_\_\_\_ Drinks/Day

Smoking \_\_\_\_\_ Packs/Day

Intravenous/Recreational Drug Use

**SIGNATURES**

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child, ever has a change in health.

|                                    |            |
|------------------------------------|------------|
| Signature _____                    | Date _____ |
| Printed Name _____                 |            |
| Parent or Guardian Signature _____ | Date _____ |
| Printed Name _____                 |            |

|                     |      |   |      |    |    |
|---------------------|------|---|------|----|----|
| For Office Use Only |      |   |      |    |    |
| BP                  | Resp | P | Temp | Ht | Wt |