Patient Information

Last Name, First Name, Middle Initial ______

Date of Birth ______ Social Security Number ______

Gender ______ Ethnic Origin ______ Marital Status ______

Home Phone ______ Work Phone ______ Mobile Phone ______

Street Address ______ City ______ State ______ Zip ______

Mailing Address ______ City ______ State ______ Zip ______

Email Address ______ Employer ______

Emergency Contact and Phone Number ______

Relationship to Patient ______

Family Physician ______ Referring Physician ______

Preferred Pharmacy ______

If not from your referring physician, how did you hear about us? ☐ Friend ☐ Newspaper/Print/ Advertising ☐ Other

Insurance Information

Primary Insurance ______ Office Copayment $ or Coinsurance% ______

Subscriber/Guarantor Name ______

Subscriber/Guarantor Address ______

Date of Birth ______ Social Security Number ______

Policy or ID Number ______ Group Number ______

Relationship to Patient ______

Subscriber/Guarantor Employer and Phone Number ______

Secondary Insurance ______

Subscriber/Guarantor Name ______ Subscriber/Guarantor Address ______

Date of Birth ______ Social Security Number ______

Policy or ID Number ______ Group Number ______

Relationship to Patient ______

Subscriber/Guarantor Employer and Phone Number ______

Patient Consent and Obligation

I acknowledge receipt of the ***Notice of Privacy Practices*** and accept and understand its terms. I authorize and request Physician and staff to provide me with any and all necessary evaluations and/or treatment. I authorize the release of/request for necessary information to/from physicians, facilities, and other caregivers that will aid in my diagnosis and care, including the review of my prescription history from external sources. I authorize the release of/request for necessary information to/from my insurance company that will aid in the payment for the services rendered. I authorize and request payment for services rendered be made directly to Physician.

I agree to abide by the terms of the ***Patient Financial Policy*** and understand that insurance and filing does not release me from being responsible for accrued charges and agree to pay my bill in full within sixty (60) days of receiving my first statement. I am aware that my account may be turned over to a third party collection service incurring an additional twenty percent (20%) fee and may result in damaged credit, court costs, attorney fees, or garnished wages.

Please note that the physicians of Idaho Falls Surgical Specialist pllc, have individual ownership interests in Mountain View Hospital. This does not limit your choice to have your surgery/procedure performed at another facility.

Signature (Patient or Parent/Authorized Guardian) ______ Date ______

Last Name, First Name, Middle Initial ____________________

Date of Birth (mm/dd/year) ____________________ Age __________ Gender __________

Chief Complaint/Reason for Visit ____________________

Referring Physician ____________________

Medications

Are you currently taking any medications? ☐ Yes ☐ No If yes, please list current medication(s) and dosage information.

Medication	Dosage	Medication	Dosage

Allergies

Do you have any allergies, including medication allergies? ☐ Yes ☐ No If yes, please list allergies.

Past Medical History

☐ **Bladder Problems**

☐ Stress Incontinence ☐ Night Time Urination ☐ Frequent Infections

☐ Defaulting Urinating Times per Night __________ ☐ Bladder Cancer

☐ **Diabetes**

☐ Borderline ☐ On Pills ☐ Insulin PM

☐ Diet Controlled ☐ Insulin AM

☐ **High Blood Pressure**

☐ No Medication ☐ On Medication

☐ **Kidney Problems**

☐ Kidney Cancer ☐ On Dialysis

☐ **Liver Problems**

☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C

☐ **Heart Problems**

☐ Chest Pain ☐ Irregular Heartbeat ☐ Heart Surgery

☐ This Week ☐ Atrial Fibrillation ☐ Angioplasty

☐ Last Month ☐ Palpitations

☐ Last Six (6) Months ☐ Heart Attack in (Year)

☐ **Shortness of Breath**

☐ Asthma ☐ CODP

☐ Emphysema ☐ Lung Cancer

☐ **Stroke**

☐ Mild ☐ Severe ☐ No Residual Problems

☐ **Blood Clots**

☐ Legs ☐ Arms ☐ Required Blood Thinners

Patient Name ____________________

☐ **Stomach Ulcer**

☐ In the Past ☐ Controlled ☐ Not Controlled

☐ **HIV Positive**

Past Surgical History

Please list the surgery/procedure and year preformed.

Year	Surgery/Procedure	Year	Surgery/Procedure

Family History

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brother(s)				
Sisters(s)				

Do you have a family history?	Y	N	Relationship to You	Relationship to You
Cancer	☐	☐		
Diabetes	☐	☐		
Heart Disease, Stroke	☐	☐		
Other ____________	☐	☐		

Social History

Indicate if you use any of the following, including the amount and frequency.

	Y	N	Amount	How Often		Y	N	Amount	How Often
Caffeine	☐	☐			**Tobacco**	☐	☐		
Alcohol	☐	☐			**Drugs**	☐	☐		
Other ________	☐	☐			**Other** ________	☐	☐		

Your Occupation

Indicate if you work exposes you to:

☐ High Stress ☐ Hazardous Substances ☐ Heavy Lifting

☐ Other (Describe) ____________________

Constitutional Symptoms

☐ Severe Headaches ☐ Weakness ☐ Night Sweats ☐ Sensitive to Cold

☐ Dizzy Spells ☐ Marked Weight Loss ☐ Persistent Fever

☐ Fatigue ☐ Marked Weight Gain ☐ Sensitive to Heat

Patient Name ____

Eyes

- ☐ Trouble Seeing
- ☐ Eye Pain
- ☐ Floaters
- ☐ Inflamed Eyes
- ☐ Double Vision
- ☐ Cataracts
- ☐ Wear Contacts
- ☐ Wear Glasses
- ☐ Vision Loss
- ☐ Blindness

Ears, Nose, Mouth and Throat

- ☐ Loss of Hearing
- ☐ Ringing in Ears
- ☐ Discharge from Ears
- ☐ Dizziness
- ☐ Frequent Ear Infections
- ☐ Ear Tube Placement
- ☐ Loss of Smell
- ☐ Frequent Colds
- ☐ Difficult Nasal Breathing
- ☐ Excessive Nasal Drip
- ☐ Nose Bleeds
- ☐ Snoring
- ☐ Sore Mouth
- ☐ Sore Gums
- ☐ Sore Tongue
- ☐ Bleeding Gums
- ☐ Dental Problems
- ☐ Dentures
- ☐ Tooth Ache
- ☐ Postnasal Drip
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Pain with Swallowing
- ☐ Goiter
- ☐ Neck Stiffness
- ☐ Neck Swelling

Endocrine

- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Goitter
- ☐ Taking Thyroid

Lungs

- ☐ Persistent Cough
- ☐ Productive Cough
- ☐ Cough Up Blood
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ History of Asthma
- ☐ History of Bronchitis
- ☐ History of COPD
- ☐ History of Emphysema
- ☐ Lung Cancer, Self
- ☐ Lung Cancer, Family
- ☐ Pneumonia
- ☐ Pulmonary Embolus
- ☐ Tuberculosis

Breasts

- ☐ Lumps
- ☐ Discharge
- ☐ Armpit Swelling
- ☐ Fibrocystic Disease
- ☐ Breast Cancer, Self
- ☐ Breast Cancer, Family

Heart

- ☐ Angina
- ☐ Atrial Fibrillation
- ☐ Slow Heart Rate
- ☐ Rapid Heart Rate
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Leg Pain When Walking
- ☐ Rheumatic Fever
- ☐ Congestive Heart Failure
- ☐ Ankle Swelling
- ☐ Shortness of Breath
- ☐ Pacemaker
- ☐ Prior Heart Arteriogram
- ☐ Heart Attack
- ☐ Prior Heart Surgery
- ☐ Blood Clots

Gastrointestinal

- ☐ Constipation
- ☐ Diarrhea
- ☐ Painful Swallowing
- ☐ Gallstones
- ☐ Heartburn
- ☐ Hiatal Hernia
- ☐ Loss of Appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting of Blood
- ☐ Tar Black Stool
- ☐ Bloody Bowel Movement
- ☐ Jaundice
- ☐ Colon Cancer, Self
- ☐ Colon Cancer, Family
- ☐ Duodenal Ulcer
- ☐ Stomach Cancer
- ☐ Stomach Ulcer
- ☐ Hemorrhoids
- ☐ Weight Loss

Gynecologic

- ☐ Use Birth Control Pill
- ☐ Taking Hormones
- ☐ Irregular Periods
- ☐ Heavy Periods
- ☐ Painful Intercourse
- ☐ Cervical Cancer, Self
- ☐ Cervical Cancer, Family
- ☐ Ovarian Cysts
- ☐ Ovarian Cancer, Self
- ☐ Ovarian Cancer, Family
- ☐ Uterine Cancer, Self
- ☐ Uterine Cancer, Family
- ☐ Pelvic Infections
- ☐ Uterine Fibroids

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Patient Name ______________________________

Men's Health

☐ Enlarged Prostate
☐ Lump in Groin
☐ Scrotal Pain
☐ Scrotal Swelling
☐ Undescended Testicle
☐ Hard Testicle
☐ Hernia

Genitourinary

☐ Stress Incontinence
☐ Difficult Urination
☐ Frequent Urination
☐ Painful Urination
☐ Painful Intercourse
☐ Loss of Sex Drive
☐ Kidney Disease
☐ Dialysis
☐ Urinary Incontinence
☐ Frequent Bladder Infection
☐ Frequent Night Urination

Musculoskeletal

☐ Muscle Cramps
☐ Muscle Weakness
☐ Generalized Aches
☐ Ankle Pain
☐ Arthritis
☐ Back Pain
☐ Cervical Disc Disease
☐ Elbow Pain
☐ Lumbar Disc Disease
☐ Joint Stiffness
☐ Joint Swelling
☐ Knee Pain
☐ Neck Pain
☐ Shoulder Pain
☐ Wrist Pain
☐ Cramps with Walking
☐ Leg Cramps at Night

Skin

☐ Acne
☐ Hair Loss
☐ Change in Hair
☐ Change in Nails
☐ Skin Ulcers
☐ Rash
☐ Melanoma, Self
☐ Melanoma, Family
☐ Psoriasis
☐ Basal Cell Carcinoma
☐ Squamous Carcinoma
☐ New or Change in Mole

Neurological

☐ Dementia
☐ Disc Problem
☐ Dizziness
☐ Migraines
☐ Multiple Sclerosis
☐ Passing Out
☐ Depression
☐ Seizure
☐ Anxiety
☐ Sleeplessness
☐ Poor Balance
☐ Weakness
☐ Memory Loss
☐ Paralysis
☐ Parkinsonism
☐ Prior Stroke
☐ TIA
☐ Numbness

Your signature indicates you have reviewed and thoroughly completed all four (4) pages associated with your pre-appointment documents.

Signature (Patient or Patient/Authorized Guardian)

____

Date

____

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Patient Financial Policy

(Effective May 14, 2012: 11/14/2012)

We are dedicated to providing you with the best possible care and service, and consider your understanding of this financial policy an essential element of the services of your surgeon and Idaho Falls Surgical Specialist. Fees associated with your surgeon usually include a clinical or hospital visit charge and a charge for your procedure or surgery.

OFFICE VISIT

We require either your applicable office copayment and/or coinsurance at the time of your visit.

PROCUDURE/SURGERY

We require a prepayment prior to your procedure or surgery. This prepayment may include your remaining deductible and/or your estimated copayment and/or your coinsurance responsibility depending on your insurance plan. Failure to make your prepayment may result in the cancelation of your procedure/surgery.

BILLING PROCESS

After you have received care, we will bill your insurance. Once we receive insurance payment information, you will receive a statement with the remaining balance. This balance is due in full within sixty (60) days.

DISCOUNTS FOR INSURED PATIENTS

Idaho Statute 41-348(b)(2) prohibits healthcare service providers from regularly waiving, rebating, giving, paying, or offering to waive, rebate, give, or pay all or a part of a claimant's deductible or claim for health insurance.

PRIVATE/SELF PAY

Two payment options are extended to private/self pay patients. The first is a thirty percent (30%) discount off of charges if the amount is paid in full prior to procedure/surgery. The second is a prepayment of fifty percent (50%) of the charges with the remaining balance paid at a minimum monthly payment of $100.00 – to be paid in full within one (1) year of your procedure/surgery date.

PAYMENTS

Balances remaining thirty (30) days beyond your first statement will begin accruing interest at an annual interest rate of eighteen percent (18%). A minimum monthly payment of $100.00 – to be paid in full within a year is due on any remaining balance. A $35.00 fee will be charged for all returned checks not honored by your bank. One missed payment will result in a reminder call and the second missed payment will result in your account being turned over to an outside collection agency with an additional twenty percent (20%) fee applied.