the Surgeons' Group, P.C.

The Surgeons Group PC
917 Tuscaloosa Ave SW
Birmingham, AL 35211
(205) 780-7150

PATIENT INFORMATION

NAME (Last, First Middle)			MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	CITY, STATE ZIP		REFERRING PHYSICIAN		SECONDARY/BILLING ADDRESS		ETHNICITY
HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER		CITY, STATE ZIP		RACE
MARITAL STATUS	STUDENT STATUS ☐ Full-Time ☐ Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME		CONTACT PHONE	HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)			SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	CITY, STATE ZIP			SECONDARY/BILLING ADDRESS (if Applicable)		
HOME PHONE	DAY PHONE	EMAIL ADDRESS		CITY, STATE ZIP		
MARITAL STATUS	STUDENT STATUS ☐ Full-time ☐ Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE	
RELATIONSHIP TO PATIENT						

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#
ADDRESS OF INSURANCE COMPANY			COPAY AMT $
CITY, STATE ZIP	PHONE		DEDUCTIBLE $
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

Consent for Treatment/ Release of Information-I consent to necessary medical treatment as determined by my physician that may be used by the physician/staff of TSG. I authorize TSG, PC to use and disclose protected health information (PHI) about me to carry out treatment, payment, and operations. (TSG Notice of Privacy provides details on such use and disclosure) Assignment of Benefits and Guarantee of Account - I hereby authorize payment directly to TSG, PC of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits. I understand that I am financially responsible to TSG, PC for charges not covered by this assignment. For services furnished by TSG, PC I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for service

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

Patients Name_____DOB_____Date of service_____

Patient History

Referring Physician_____

Reason for visit:_____

Physician Notes:_____

Past Medical History
( ) High Blood Pressu( ) Lung Disease ( ) Asthma ( ) Diabetes ( ) Seizures ( ) Thyroid

( ) Kidney/Bladder ( ) Strokes ( ) Hepatitis ( ) HIV ( ) Heart Disease ( ) Other

( ) Blood Transfusion( ) Cancer of _____ ( ) Obstructive Sleep Apnea

Past Surgical History(Include year of procedure)

_____
_____
_____
_____

Current Medications(including vitamins and over the counter medications)

_____
_____
_____
_____

Allergies_____

Health Maintenance
Women:
Last PAP smear_____Last Mammo_____Last colonoscopy/stool for blood_____

Men: Last PSA _____ Last colonoscopy/stool for blood_____

Family History (Please check all that apply)
__ High Blood Pressure __Liver Disease __Heart Disease __Ulcers __Diabetes __Thyroid
__Kidney __Cancer __Other_____

Social History (Please check all that apply)
_____ Smoke ___ Packs per day for ____years
_____ Alcohol _____use for ____years
_____ Illicit Drugs _____use for _____years

Marital Status: _____
Occupation:_____

Patient Name:_____ DOS_____DOB_____

Review of Systems(Please circle all that apply)

Constitution:	weight loss weight gain night sweats fevers
Skin:	change in size/ color of moles rash bruising
Eyes:	poor vision double vision blurred vision glasses
Nose/Ears:	pain deafness ringing in ears sinus drainage nose bleeds
Cardiac:	palpitations chest pain shortness of breath swelling feet/legs
Respiratory:	cough production of sputum coughing up blood
Gastro:	painful swallowing nausea vomiting reflux diarrhea constipation /change in bms /bloody stools /vomiting blood
G/U:	kidney/bladder disease decreased urine stream /pain in urination blood in urine /inability to urinate
Muscle/skeleton:	weakness trauma limited motion /bone/joint deformity
Neuro:	paralysis weakness seizure fainting numbness tingling
Psych:	anxiety depression hallucinations
Endocrine:	change of appetite excessive thirst/urination
Hemato:	bleeding disorders blood thinner use
Immuno:	immune disorders immunosuppression

Females Only

Last Menstrual cycle: _____ Onset of Menses _____

Number of Pregnancies_____ Number of Children _____

Current method of birth control _____

Dr. Signature: _____

Date: _____