Shore Surgical Associates

. . . . a division of Shore Health Services, Inc.®

PATIENT REGISTRATION

Please fill out this information on the patient. We will make copies of your insurance card(s).

Name: ______________________________ Single / Married / Widowed / Divorced

911 address: ______________________________

Mailing address: ______________________________

City: ______________ State: ______________ Zip: ______________

Home phone: ( ) ______________ Cell phone: ( ) ______________

Gender: M / F Birth date: ______________ Age: ______________

Social Security #: ______________

Your occupation: ______________________________

Your employer: ______________________________

Employer's address: ______________________________

City: ______________ State: ______________ Zip: ______________

Employer's phone: ______________________________

Spouse's name: ______________ Spouse's phone: ______________

Spouse's employer: ______________ Spouse employer ph: ______________

Who is responsible for your medical bills? Self / Employer / Other (if 'other', please provide information below):

Name: ______________________________ Relationship: ______________

Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Who should we contact in case of emergency or if we can not reach you?

Name: ______________________________ Relationship to you: ______________

Daytime phone: ______________ Evening phone: ______________

Do you have an Advanced Directive? ___YES ___NO Would you like information on Advanced Directives? ___YES ___NO

Shore Surgical Associates has my permission to

discuss my medical information with: ______________________________ (Name / Relationship)

leave messages on answering machine and/or with family members: _____YES _____NO

Other (please specify): ______________________________

Your Primary Care Physician: ______________ Your Referring Physician: ______________

AUTHORIZATION FOR TREATMENT: *I hereby give permission to the health care providers of Shore Surgical Associates and any assistants to administer treatment, medication or diagnostic testing that they may deem advisable in the care and treatment of my case. Authorization is given to Shore Surgical Associates and any assistants to contact the patient's employer or insurer regarding existing coverage of patient's insurance(s). I understand that Shore Surgical Associates will release financial, medical and other such information in accordance with Federal Law (HIPAA) as explained in the Patient Notice of Privacy Practices booklet. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Shore Surgical Associates and of my rights with respect to my health information.*

____I have received. _____I have been offered and refused.

Briefly explan why the patient was not able or willing to sign this form: ______________________________

*Patient or Responsible Party Signature:*______________________________ *Date:*______________

I authorize the release of any medical information necessary to process insurance claims and request that payment of benefits be made to Shore Surgical Associates. I understand that if I am referred to another doctor or for diagnostic testing, it is my responsibility to obtain an

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insurance referral. I understand that I am financially responsible for all charges for services rendered by the health care provider. Even though I may carry health insurance, I understand that I will be responsible for any charges that are not covered by my health insurance policy. I understand that my co-pay is to be paid at the time of service.

*Patient or Responsible Party Signature:*____ *Date:*__________________

MEDICAL HISTORY

If you are currently taking any medications, please list them here: ____

____

Please list any surgeries you have had: ____

____

DO YOU HAVE A HISTORY OF:	YES	NO
CLOTS IN LEGS OR LUNG		
HEART DISEASE		
SEIZURES		
HARD OF HEARING		
ASTHMA		
CVA / STROKE		
HIGH BLOOD PRESSURE		
DIABETES		
HISTORY OF ULCER		
ANXIETY		
DEPRESSION		
CANCER		
OTHER:____________________		

DO YOU HAVE ANY OF THESE SYMPTOMS?	YES	NO
HEADACHES / DIZZINESS		
DOUBLE / BLURRED VISION		
EAR ACHES		
SORE THROAT		
CHRONIC COUGH		
NOSE BLEEDS		
SHORTNESS OF BREATH		
NAUSEA / VOMITING		
CHEST PAIN		
CONSTIPATION		
DIARRHEA		
BLOOD IN YOUR STOOL		
UNEXPLAINED / RECENT WEIGHT LOSS		
URINARY FREQUENCY		
NERVOUS ILLNESS		

DO YOU SMOKE? ____ YES ____ NO
If 'Yes', number of packs per day: _______
Have you quit? Quit date: _______________________

HOW OFTEN DO YOU DRINK ALCOHOLIC BEVERAGES?
(circle one) Never, Occasional, Moderate, Heavy

ARE YOU ALLERGIC TO ANY MEDICINES? ____YES ____NO
If 'Yes', please specify: ______________________________
____

ANY OTHER ALLERGIES? ____YES ____NO
If 'Yes', please specify: ______________________________

DO YOU HAVE A FAMILY HISTORY OF:	Diabetes	High Blood Pressure	Heart Disease	Cancer: If 'Yes", List Type(s)
Father	Yes / No	Yes / No	Yes / No	Yes / No
Mother	Yes / No	Yes / No	Yes / No	Yes / No
Brother	Yes / No	Yes / No	Yes / No	Yes / No
Sister	Yes / No	Yes / No	Yes / No	Yes / No
Grandparents	Yes / No	Yes / No	Yes / No	Yes / No
Other	Yes / No	Yes / No	Yes / No	Yes / No

For Women only:
# of pregnancies: ___________ # of children: ________________ Date of last mammogram? _________________

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