OAK RIDGE SURGEONS, PC
general and vascular

Name (First, Middle, Last): ______________________________

Mailing Address: ______________________________

City/State/Zip: ______________________________

Street Address (if different from above): ______________________________

City/State/Zip: ______________________________

Home Phone: (____)__________ Sex: __________ Cell Phone: (___)__________

Date of Birth: __________ Age: __________ Beeper: (___)__________

Social Security #: ______________________ Marital Status: __________

Spouse (or parent's if minor) Name: ______________________________

Patient's Employer: ______________________ Work Phone: (___)__________

Spouse's Employer: ______________________ Work Phone: (___)__________

Emergency Contact (other than spouse) Name ______________________________

Phone Number: (___)______________________________

Relationship: ______________________________

Who referred you to this office? (Doctor/Other): ______________________________

Primary Care Physician and Office Number: ______________________(___) __________

★★★

1. Insurance: ______________________ Policy Holder's DOB: __________

Policy Holder's Name: ______________________ Policy Holder's SS#: __________

2. Insurance: ______________________ Policy Holder's DOB: __________

Policy Holder's Name: ______________________ Policy Holder's SS#: __________

Is this a result of a motor vehicle accident, workman's comp injury, or other? __________

If so, please provide information: ______________________________

All patients please read and sign if applicable:

I hereby request any physician, hospital, or other facility to furnish Oak Ridge Surgeons, P.C. all records regarding any medical treatment including reports, test, x-rays, or other information they request. This request cancels all prior requests.

Signature: ______________________________ **Date:** __________

<u>Medicare Patients please read and sign:</u> (Medicare extended payment request one time authorization)

I request that payment of authorized Medicare benefits be made to Oak Ridge Surgeons, P.C. for any services furnished me by that provider. I authorize any holder of medical information about me to release to Health Care Financing Administration (now CMS Centers for Medicare and Medicaid Services) and its agents any information needed to determine these benefits or the benefits payable for related services. (**Medigap patients -** ***if applicable)***. I also request that payment of authorized Medigap benefits be made on my behalf to above listed provider and authorize release of medical information required to determine these benefits.

Signature: ______________________________ **Date:** __________

CONTACTING YOU

There may be occasions in which our office needs to contact you concerning your appointment, diagnostic testing results, or billing problems or any other situation relating to your visit at our office. Please read and answer the following questions.

I give my permission to this office to call the home number I've listed on the reverse side and leave test results, appointments, and other information pertaining to me to anyone answering the telephone or on an answering machine.
YES **NO**

I give permission to this office to call the work number I've listed on the reverse side and leave test results, appointments, and other information pertaining to me to anyone answering the telephone or on an answering machine.
YES **NO**

PRIVACY POLICY

I have been offered a copy of the Notice of Privacy Practices.
YES **NO**

GENERAL AUTHORIZATION

ASSUMPTION OF RESPONSIBILITY: The undersigned agrees, whether he/she signs as an agent or as a patient, that in consideration of services to be rendered to the patient named above he he/she obligates themselves and agrees to pay upon demand to the above named Provider all charges for such services and incidentals incurred by said patient. Should the account be referred to an attorney for collection, the undersigned shall pay all reasonable attorney fees and collection expenses. All delinquent accounts to bear interest at the legal rate. It is understood that bills are payable upon presentation.

ASSIGNMENT OF INSURANCE BENEFITS: I / We hereby guarantee payment of all charges incurred for the account of the above said patient from the date of first treatment until discharge or termination of treatment, and hereby assign any hospital insurance benefits, insurance sick benefits, or injury benefits payable because of liability of a third party payable to or for the above said patient unless accounts for said patient have been paid in full.

AUTHORIZATION TO RELEASE INFORMATION:

I / We hereby agree that the above named Provider may release the Patient's health information as follows:

- To the Patient's insurance company or companies;
- To the Patient's family, friends, or others involved with the a Patient's care;
- To the Provider's employer, agent or other third party acting either on behalf of the Provider or pursuant to and agreement with the Provider;
- As necessary for research purposes described in the Notice of Privacy Practices:
- To the Patient's employer if the Provider provides health care to the Patient at the request of the employer to conduct an evaluation relating to medical surveillance of the workplace or to determine whether the Patient has a work-related illness or injury, provided that the employer needs the information to comply with certain laws regarding workplace safety. Such information will be limited to finding concerning a work-related illness or injury or workplace-related medical surveillance;
- For the specialized government functions described in the Notice of Privacy Practices;
- To funeral directors, coroners, or medical examiners as necessary to perform their functions; and to organ procurement organization.

Signature:_____ Date:_____

Health Information

Name_____ Date_____
Maiden Name_____ Age_____ Date of Birth_____
Referring Doctor_____ Family Physician_____

List all previous surgeries and their approximate dates:

_____ Appendectomy	_____ Breast	_____ Vascular
_____ Gallbladder	_____ Colon	_____ Hernia
_____ Hysterectomy	_____ Heart	_____ Other
_____ Other	_____ Other	_____ Other

Do you have, or have had problems with:

❑ High Blood Pressure	❑ Bloody Stool	❑ Arthritis	❑ Diabetes	❑ HIV/AIDS	❑ Blood Thinner
❑ Blood Clots	❑ Lung/Breathing	❑ Stroke	❑ TB	❑ IV Dye Allergies	❑ Latex Allergy
❑ Kidney Disease	❑ Heart	❑ Cancer	❑ Thyroid	❑ Pneumonia	❑ Sleep Apnea
❑ Hepatitis	❑ Ulcers	❑ Other	❑ Other	❑ Other	

List all medications, dosage, and how often you take them, including aspirin, blood thinner, etc.

_____
_____
_____
_____

Are you allergic to any medications or foods? if so, what: _____
_____

Have you had any problems with anesthesia? (explain) _____
Have you had any blood transfusions?_____
Do you require any special diet? if so, what kind?_____
Do you or did you use tobacco? if so, what form?_____
How much? _____How often?_____When did you quit?_____
Do you drink alcohol? if so, how much?_____How often? _____
Do you wear dentures?_____Upper_____ Lower _____ None _____

Last dates and locations for:

Hospitalization _____ _____
DATE location

Chest x-ray_____ _____
DATE location

EKG _____ _____
DATE location

How many pregnancies have you had?___ How many were live births?___ Did you breast feed?___
Occupation _____ Hobbies _____

Any family history of the following:

❑ Heart Disease ❑ Strokes ❑ Cancer ❑ Diabetes

Name of your pharmacy_____ Telephone Number _____
What is the reason for today's visit? _____
Do you have a home health agency? ❑ Yes ❑ No
Please give name _____ Telephone Number _____

OAK RIDGE SURGEONS P.C.
120 ADMINISTRATION RD., OAK RIDGE, TN 37830 865-483-7030

APPOINTMENT CANCELLATION AND NO-SHOW POLICY

Last minute cancellation and same day no-shows make it difficult to serve other patients who are waiting to be scheduled. We ask that you give a twenty four (24) hour notice of cancellation or reschedule prior to your appointment if you will be unable to keep that appointment. We will be happy to reschedule your appointment. Scheduled appointments that you do not show up for, will result in a $25.00 fee. No show fees are the sole responsibility of the patient and will be billed to the patient.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

OUR POLICY OF CARE AND PAYMENT

Ensuring that our patients receive high quality care is the goal of our practice

We accept cash, check, Visa, Master Card, and American Express. We also have a payment plan called CareCredit that allows you to spread payments over time.

Applying for CareCredit only takes a few minutes and there is no fee to apply.

Please indicate below the form of payment you choose to settle your account: check one

- Cash
- Check
- Credit Card
- Care Credit (subject to credit approval). If credit application is declined, another form of payment listed above is required.

_____

Signature of patient / responsible party

_____

Date