WYOMING SURGICAL ASSOCIATES, P.C.

Todd H. Beckstead, M.D. **Clayton E. Turner, M.D.**
Aimee E. Gough, M.D. **Hillary Morrison, D.O.**

MEDICATIONS CURRENTLY TAKING

Date: _____

Patient's Name: _____ Date of Birth: _____

ARE YOU CURRENTLY TAKING ANY BLOOD THINNERS? YES _____ NO _____

ARE YOU DIABETIC? YES _____ NO _____

PLEASE LIST ALL ALLERGIES:_____

_____

Which Pharmacy do you want us to send prescriptions to? _____

Name of Medication	Dose (mg)	How often do you take?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient's Signature: _____

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PATIENT INFORMATION

Date: _____ Referring Dr or Primary Care Dr if not referred:_____

Patient Legal Name: _____ Age: _____ Birth date: _____

Mailing Address: _____

City, State, Zip Code: _____

Home Phone: _____ Cell Phone: _____ Social Security #: _____

Email address: _____

Marital Status: Single____ Married_____ Divorced_____ Widowed_____ Male ___ Female ___

Employer: _____ Employer Phone Number: _____
If retired, please put retired/date of retirement. If student, please put name of school/part or full time

SPOUSE INFORMATION

Spouse Name: _____ Age: _____ Birth date: _____

Social Security Number: _____ Employer: _____
(If retired, please put retired/date of retirement)
Employer Phone Number: _____ Cell Phone: _____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT PLEASE FILL IN BELOW)

Name & Relationship: _____Social Security Number: _____

Mailing Address: _____ Birth Date: _____

City, State, Zip: _____

Employer: _____ Phone Number: _____

EMERGENCY INFORMATION

Name of friend or relative: _____ Relationship: _____

Phone Number: _____ Address: _____

City, State, Zip: _____

Please note that we now require a copy of your Medicare, Medicaid and or Insurance Card to verify the mailing address, phone number and the spelling of your name as shown on each individual card. We can not file insurance claims for you without the birthdate and social security number of the policy holder.

We are also requiring a copy of your driver's license or other picture id that includes your signature. This is to be able to verify your identity in the event of requests for release of Private Health Care information.

We appreciate your help and understanding of these requests.

PRIMARY INSURANCE INFORMATION

Primary Insurance Carrier: _____

Insurance Policy Number: _____

Insurance Group Number: _____

Insurance Company Address: _____

Insurance Company Phone Number (member services):_____

Name of Insurance **Policy Holder**: _____

Relationship of **Policy Holder** to you: _____

Policy Holder's Birth date: _____ **Policy Holder's** Social Security Number: _____

SUPPLEMENTAL INSURANCE INFORMATION

Supplemental Insurance Carrier: _____

Supplemental Insurance Policy Number: _____

Supplemental Insurance Group Number:_____

Supplemental Insurance Company Address: _____

_____

Name of Supplemental Insurance **Policy Holder**: _____

Relationship of Supplemental **Policy Holder** to you: _____

Supplemental **Policy Holder's** Birth date: _____Supplemental **Policy Holder's** Social Security Number: _____

AUTHORIZATION AND FINANCIAL UNDERSTANDING

- By accepting the medical services provided to me by Todd H. Beckstead, MD, Hillary Morrison, DO, Aimee E. Gough MD, and/or Clayton E Turner, MD or any other employee of the corporation, I agree to be financially responsible for the charges billed by Wyoming Surgical Associates, P.C. for those services.
- If there is medical insurance which will cover all or a portion of the charges I incur by Todd H. Beckstead, MD, Hillary Morrison, DO, Aimee E. Gough, MD and/or Clayton E Turner, MD or any other employee of the corporation for my treatment, I hereby assign those insurance benefits to Wyoming Surgical Associates, P.C., and authorize the insurance benefits to be paid directly to Wyoming Surgical Associates, PC. This assignment will remain in effect until revoked by me in writing.
- I understand and agree that if my insurance benefits do not cover all of the charges for my treatment, including what my insurance company classifies as over reasonable and customary charges, that I am responsible to pay any outstanding balances. I further agree that in the event of non-payment to Wyoming Surgical Associates, PC of any amounts due under this agreement I will pay interest thereon at the rate of 1.75% per month and pay all of Wyoming Surgical Associates, PC reasonable legal fees, attorney fees and court costs that may be incurred. I agree that in the event this agreement is assigned to a collection agency for collection I promise to pay a collection fee of 35% of the unpaid balance due which is in addition to the unpaid balance due under this agreement.
- I understand that it may be necessary for Wyoming Surgical Associates, P.C. to disclose medical information about my treatment to my insurance companies, employer, or third-party payers in order to process a claim on my behalf.
- A photocopy of this assignment and financial agreement is to be considered as valid as the original.
- I understand that by signing this I agree for providers to download my medication history
- **I understand that it is my responsibility to contact my insurance company for pre-authorization on procedures.**

I hereby give my permission for any employee of Wyoming Surgical Associates, PC as well as any physician's office or facility to which I may be referred to contact me at:

1. My work phone
2. My work phone and leave a message to call back
3. My home phone and leave a message to call back
4. My home phone and leave a detailed message on either an answering machine or with whoever answers the phone.
5. Any other verbal or written contact I have provided to your office for both call back and detailed messages.

Please cross out any of the above that you do not want us to do.

Signature of Patient/Guardian: _____ Date: _____

Name: _____ Date:_____

Patient name: _____ **Patient date of birth:** _____

Chief Complaint (symptoms):

_____

HISTORY OF PRESENT ILLNESS:

1. **How long have you had this problem?** _____
2. **What makes your problem worse?** _____
3. **What makes your problem better?** _____

REVIEW OF SYSTEMS:

Circle **any problems that you have experienced recently or for prolonged periods in the past:**

General: **W**eight loss **W**eight gain **W**eakness **F**ever **C**hills **N**ight sweats

Skin: **R**ash **N**on-healing wounds

Eyes: **B**lurred vision **L**oss of vision **G**laucoma

Ears: **D**eafness **R**inging **D**ischarge **P**ain

Nose: **B**leeding **D**ischarge **O**bstruction

Mouth: **B**leeding gums **S**ore areas **O**pen wounds

Throat: **R**ecent sore throat **D**ifficulty swallowing **H**oarseness **T**onsillitis

Neck: **P**ain **S**tiffness

Breasts: **D**ischarge **L**umps **P**ain **B**leeding

Lungs: **C**ough **S**putum change **C**oughing of blood **S**hortness of breath

Heart: **P**ain in chest **S**welling of legs **H**istory of Rheumatic Fever

Fluttering of heart **H**eart murmur

Vascular: **P**ain or cramps in legs after walking **V**aricose veins **D**VT (Blood Clot)

Gastrointestinal: **N**ausea Vomiting **V**omiting of blood **H**eartburn

Black stools **D**ark urine **H**ernia

Urinary tract: **P**ain on urination **D**ribbling **L**oss of urine **B**lood in urine

Musculoskeletal: **B**roken bones **A**rthritis **S**tiff joints **M**uscle weakness **S**lurred speech

Neurological: **S**eizures **N**umbness **P**aralysis **H**eadache

Psychiatric problems: **D**epression **N**ervousness **A**ltered sleep (more or less) **C**hange in appetite

PAST MEDICAL HISTORY:

Heart Disease (including heart attack, angioplasty, coronary bypass surgery)? Yes No

Any other medical or health problems? _____

PAST SURGERIES: _____

SOCIAL HISTORY: **M**arried **S**ingle **D**ivorced **W**idowed

Number of children? _____ Type of employment?_____

Habits? **S**moke **C**hewing Tobacco **A**lcohol **D**rug Use **E**xercise

FAMILY MEDICAL HISTORY:

Mother? **L**iving **D**eceased If deceased, cause of death?_____

Father? **L**iving **D**eceased If deceased, cause of death?_____

History of any of the following in family? **H**eart Disease **D**iabetes **L**ung Disease

Cancer (Breast Colon Other)