

WYOMING SURGICAL ASSOCIATES, P.C.

Todd H. Beckstead, M.D.

Thomas J. Adams, M.D.

Aimee E. Gough, M.D.

Hillary Morrison, D.O.

Riley Moore, M.D.

MEDICATIONS CURRENTLY TAKING

Date: _____

Patient's Name: _____

Date of Birth: _____

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

ARE YOU DIABETIC? YES _____ NO _____

ARE YOU CURRENTLY TAKING WEIGHT LOSS MEDICATION? YES _____ NO _____

DO YOU HAVE ANY ALLERGIES? 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 ___ Birth Sex M / F

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

If Medicare secondary, please indicate reason () Working age () Spouse working age () Disability

Supplemental Insurance Carrier: _____

Supplemental Ins Policy Number: _____ Supplemental Ins Group Number: _____

Supplemental Insurance Company Address: _____

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

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

Policy Holder's Birth date: _____ **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, Riley Moore, MD, and/or Thomas Adams, 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, Riley Moore, MD, Aimee E. Gough, MD, and/or Thomas Adams, 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.
- WSA has a No-show/same-day cancellation policy. If you fail to provide more than 24 hours notice of cancellation on two occasions, you will not be permitted to schedule another appointment without paying a deposit. If you show for that next appointment, your deposit will be refunded to you. If you fail to give 24 hours callenation notice, WSA will keep that deposit. Cancellation deposit amounts are \$150 for office visits and \$250 for procedures/surgeries.
- 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 and leave a message to call back
2. My home phone and leave a detailed message on either an answering machine or with whoever answers the phone.
3. 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? _____

4. **REVIEW OF SYSTEMS:**

Constitutional				Neurologic				Genitourinary/ Nephrology		
Night Sweats	Y	N		Alteration of consciousness	Y	N		Breast Pain/Changes	Y	N
Recent Illness	Y	N		Dizziness	Y	N		Breast Drainage	Y	N
Chills	Y	N		Memory Loss	Y	N		Side Pain	Y	N
Excessive sweating	Y	N		Tingling or numbness	Y	N		Hernia	Y	N
Fatigue	Y	N		Seizures	Y	N		Pelvic Pain	Y	N
Fever	Y	N		Weakness	Y	N		Testicular Pain	Y	N
Weight gain/obesity	Y	N						Urinary incontinence	Y	N
Weight Loss	Y	N		Endocrine				Renal Failure	Y	N
				Diabetes Type 1	Y	N				
Ears/Nose/Throat/Neck				Diabetes Type 2	Y	N		Dermatologic		
Cancer of head or neck	Y	N		Adrenal Insufficiency	Y	N		Eczema	Y	N
Gastroesophageal Reflux	Y	N		Goiter	Y	N		Mole Changes	Y	N
Headache	Y	N		Breast tissue enlargement male	Y	N		Sores	Y	N
Hearing Loss	Y	N		Thyroid Nodule	Y	N		Cellulitis	Y	N
Laryngeal Mass	Y	N						Skin Cancer	Y	N
Neck Mass	Y	N		Eyes						
Sore Throat	Y	N		Blindness	Y	N		Psychiatric		
Sleep Apnea	Y	N		Cataract	Y	N		Alcohol Abuse	Y	N
				Glaucoma	Y	N		Anxiety	Y	N
Gastrointestinal				Macular Degeneration	Y	N		Depression	Y	N
Hemorrhoids	Y	N						Drug Abuse	Y	N
Abdominal Pain	Y	N		Cardiovascular				Suicidality	Y	N
Constipation	Y	N		Arrythmia	Y	N				
Diarrhea	Y	N		Chest Pain/Pressure	Y	N		Hematologic/Lymphatic		
Gas and Bloating	Y	N		Shortness of breath	Y	N		Abnormal Bleeding	Y	N
Nausea	Y	N		Edema	Y	N		Anemia	Y	N
Anal itching	Y	N		Exercise Intolerance	Y	N		Pulmonary Embolus	Y	N
Vomiting	Y	N		Hypertension	Y	N		Venous Thrombosis	Y	N
				Palpitations	Y	N				
Musculoskeletal										
Stiffness	Y	N		Respiratory						
Swelling	Y	N		Asthma	Y	N				
Joint pain	Y	N		Chest Congestion	Y	N				
Bone Pain	Y	N		Chest Tightness	Y	N				
Muscle Weakness	Y	N		Cough	Y	N				
Muscle soreness	Y	N		Shortness of breath on Exertion	Y	N				
Osteoporosis	Y	N		Wheezing	Y	N				

PAST MEDICAL HISTORY:

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

Any other medical or health problems? _____

PAST SURGERIES: _____

SOCIAL HISTORY: Married Single Divorced Widowed

Number of children? _____ Type of employment? _____

Habits? Smoke Chewing Tobacco Vape Alcohol Drug Use Exercise

FAMILY MEDICAL HISTORY:

Mother? Living Deceased If deceased, cause of death? _____

Father? Living Deceased If deceased, cause of death? _____

History of any of the following in family? Heart Disease Diabetes Lung Disease

Cancer (Breast Colon Other)