

# PATIENT REGISTRATION FORM

## PATIENT INFORMATION

ACCT. NUMBER \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ - \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_ Marital Status \_\_\_\_\_ Soc.Sec. No. \_\_\_\_\_  
Home Phone \_\_\_\_\_ Bus. Phone \_\_\_\_\_ Emer. Phone No. \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Spouse's Soc.Sec.No \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_ Spouse's Bus. No. \_\_\_\_\_  
Religious Affiliation \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION(IF OTHER THAN ABOVE)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ - \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ Relationship to Pt. \_\_\_\_\_  
Employer \_\_\_\_\_ Home Phone \_\_\_\_\_ Bus. Phone \_\_\_\_\_

## INSURANCE INFORMATION - PLEASE PRESENT YOUR CARDS TO THE RECEPTIONIST

Name of Primary Insurance \_\_\_\_\_  
Contract/Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_  
Subscriber \_\_\_\_\_ Date of Birth \_\_\_\_\_ Rel to Pt. \_\_\_\_\_  
Name of Secondary Insurance \_\_\_\_\_  
Contract/Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_  
Subscriber \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to Pt. \_\_\_\_\_  
Is this a Workmens's Compensation Claim? If yes, Give accident date \_\_\_\_\_

Name of Referring Physician \_\_\_\_\_

I acknowledge and agree that I am fully responsible for payment of all charges for any services rendered by Surgical Specialists of AL., P.C., and for payment of any balance not paid by insurance when due, and I agree to pay any such charges. I further reaffirm and agree to pay all previously incurred and unpaid charges I may owe said Surgical Specialists of AL., P.C. If my account becomes delinquent, I agree to pay all costs of collections, including a reasonable attorney's fee of one-third(1/3) of the principal balance then due, if my account is place with an attorney for collections; And I waive any right I may have according to the Constitution and Laws of the State of Alabama to claim exemptions as to personal property as to this obligation.

I consent to treatment necessary for medical care. I authorize the release of all medical records to the referring and family physicians. I authorize release of medical records to insurance carriers concerning my illness and treatments. I allow fax transmittal of such records if necessary. I authorize payment of benefits directly to Surgical Specialists of AL., P.C., for services rendered to myself or my minor dependents.

Signature \_\_\_\_\_ Date \_\_\_\_\_

NAME \_\_\_\_\_ DATE \_\_\_\_\_

**\*\*LIST ALL PRIOR SURGERY:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*\* LIST CURRENT MEDICATIONS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*\* ALLERGIES (PLEASE CHECK IF YOU HAVE HISTORY OF ALLERGY TO THE FOLLOWING):**

<input type="checkbox"/> NO KNOWN DRUG ALLERGIES	<input type="checkbox"/> CIPRO, FLOXIN
<input type="checkbox"/> PENICILLIN	<input type="checkbox"/> ERYTHROMYCIN
<input type="checkbox"/> CEPHALOSPORINS (KEFLEX)	<input type="checkbox"/> SULFA DRUGS
<input type="checkbox"/> MORPHINE, DEMEROL, NARCOTICS	<input type="checkbox"/> MACRODANTIN
<input type="checkbox"/> CODEINE	<input type="checkbox"/> IODINE
<input type="checkbox"/> NOVACAINE, LIDOCAINE, OR ANESTHETICS	<input type="checkbox"/> X-RAY DYE
<input type="checkbox"/> ASPIRIN	<b>ANY FOOD ALLERGIES:</b>
<input type="checkbox"/> IBUPROFEN (ADVIL, MOTRIN)	_____
<input type="checkbox"/> TETANUS OR OTHER SERUMS	<b>OTHER MEDICATIONS:</b> _____
	_____

**\*\* YOUR PERSONAL MEDICAL HISTORY (PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING):**

<input type="checkbox"/> DIABETES	<input type="checkbox"/> BLOOD THINNERS
<input type="checkbox"/> CANCER	<input type="checkbox"/> ARTHRITIS/GOUT
<input type="checkbox"/> HEART TROUBLE	<input type="checkbox"/> BLEEDING TENDENCY
<input type="checkbox"/> SEIZURES/CONVULSIONS	<input type="checkbox"/> ACUTE INFECTIONS
<input type="checkbox"/> HYPERTENSION	<input type="checkbox"/> HEREDITARY DEFECTS
<input type="checkbox"/> STROKE	<input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE

OTHER: \_\_\_\_\_

**\*\* FAMILY MEDICAL HISTORY**

	AGE	DISEASES
FATHER	_____	_____
MOTHER	_____	_____
SIBLINGS	_____	_____
CHILDREN	_____	_____

**\*\* SOCIAL HISTORY**

MARITAL STATUS : SINGLE \_\_\_ MARRIED \_\_\_ SEPERATED \_\_\_ DIVORCED \_\_\_ WIDOWED \_\_\_  
 USE OF ALCOHOL: NEVER \_\_\_ RARELY \_\_\_ MODERATE \_\_\_ DAILY \_\_\_  
 USE OF TOBACCO: NEVER \_\_\_ PREVIOUSLY BUT QUIT \_\_\_ CURRENTLY/ PACKS PER DAY \_\_\_  
 USE OF DRUGS: NEVER \_\_\_ PREVIOUSLY BUT QUIT \_\_\_ CURRENTLY/TYPE/FREQUENCY \_\_\_  
 EXCESSIVE EXPOSURE AT WORK/HOME TO : FUMES \_\_\_ DUST \_\_\_ SOLVENTS \_\_\_ PARTICLES \_\_\_

**\*\*\*DO YOU HAVE AIDS OR HIV? YES NO**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

**PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING:**

- \_\_\_\_\_  
 Good General Health Lately  
 Recent Weight Change  
 Fever  
 Fatigue  
 Headaches

**EYES:**

- Wear Glasses or Contact Lenses  
 Blurred or Double Vision  
 Glaucoma

**EARS/NOSE/MOUTH/THROAT:**

- Hearing Loss or Ringing  
 Chronic Sinus Problems  
 Nose Bleeds  
 Bleeding Gums  
 Sore Throat or Voice Change  
 Swollen Glands in Neck

**CARDIOVASCULAR:**

- Heart trouble  
 Chest Pain or Angina  
 Heart Palpitations  
 Swelling- Feet/Hands/ Ankles  
 Pain in Legs With Walking

**RESPIRATORY:**

- Chronic or Frequent Cough  
 Spitting Up Blood  
 Shortness of Breath  
 Asthma or Wheezing

**GASTROINTESTINAL:**

- Loss of Appetite  
 Change in Bowel Habit/Movements  
 Nausea or Vomiting  
 Frequent Diarrhea  
 Constipation  
 Painful Bowel Movements  
 Rectal Bleeding/Blood in Stool  
 Abdominal Pain  
 Heartburn/Indigestion  
 Ulcer-Stomach or Duodenal  
 Diverticulosis/Diverticulitis

**ENDOCRINE:**

- Thyroid Disease  
 Diabetes  
 Excessive Thirst  
 Excessive Urination  
 Heat or Cold Intolerance  
 Skin Becoming Dry

**GENITOURINARY:**

- Urinary Tract Infections  
 Frequent Urination  
 Burning or Painful Urination  
 Blood in Urine  
 Kidney Stones  
 Male-Testicle Pain  
 Female- # of Pregnancies \_\_\_\_\_  
Age When You Started Your Period \_\_\_\_\_  
Age When 1st Child Born \_\_\_\_\_  
Did You Breast Feed? \_\_\_\_\_  
Birth Control Pills? \_\_\_\_\_ years

**MUSCULOSKELETAL:**

- Joint Pain  
 Joint Stiffness or Swelling  
 Weakness of Muscles or Joints  
 Back Pain  
 Cold Extremities  
 Difficulty Walking

**SKIN & BREAST:**

- Rash or Itching  
 Change In Skin Color  
 Change In Hair or Nails  
 Varicose Veins  
 Breast Pain  
 Breast Lump  
 Breast Discharge

**NEUROLOGICAL:**

- Frequent/Recurring Headaches  
 Lightheaded or Dizziness  
 Convulsions or Seizures  
 Numbness or Tingling  
 Tremors  
 Paralysis  
 Stroke  
 Head Injury

**PYSCHIATRIC:**

- Memory Loss or Confusion  
 Nervousness  
 Depression  
 Insomnia

**HEMATOLOGIC/LYMPHATIC**

- Bleeding or Bruising Easily  
 Anemia  
 Enlarged Glands/Lymph Nodes

FELLOWS OF THE  
AMERICAN COLLEGE OF SURGERY

AMERICAN BOARD OF SURGERY

AMERICAN BOARD OF  
COLON AND RECTAL SURGERY



# SURGICAL SPECIALISTS *of Alabama, P.C.*

HOWARD J. FALGOUT, M.D.  
GEORGE W. NUNN, M.D.  
JOHN O. WAITS, M.D.  
JOSEPH C. WALLACE, M.D.  
TIMOTHY W. WINKLER, M.D.

## HIPAA NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

### Uses and Disclosure of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

### Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to who you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

### Payment

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

### Healthcare Operations

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law; public health issues as required by law: communicable diseases, health oversight, abuse or neglect; Food and Drug Administration requirements; legal proceedings; law enforcement; coroners, funeral directors and organ donation; Research, criminal and military activity; National Security; Workers' Compensation; Inmates. Required use and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other permitted and required uses and disclosures will ONLY be made with your written consent, authorization or opportunity to object unless REQUIRED by LAW. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.**

**YOUR RIGHTS**

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.**

Under federal law, you have the right to inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.**

This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information is not to be disclosed to any family members or friends who may be involved in your care or for notification purposes as described in this notice of privacy practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is not in your best interest to permit use and disclosure of your protected health information, your information will not be restricted. You then have the right to use another healthcare professional if you desire.

**You have the right to request confidential communications from us by alternative means or at an alternate location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.**

**You may have the right to have your physician amend your protected health information.**

If we deny your request to the amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and provide you a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

**We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.**

**Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

**We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our office.**

**Signature below is only acknowledgement that you have received this notice of our privacy practices:**

**Print Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**SURGICAL SPECIALISTS OF ALABAMA, P.C.**  
**Non-Covered Routine Services Policy for Medicare and Blue Cross-Blue Shield**

As my patient, I want to provide you the best care possible. There may be certain routine services that I feel are necessary for the maintenance of good health that are not covered by your Blue Cross-Preferred Care contract. You will be expected to pay for those services in full. For example, I may order a mammogram, chest x-ray, or surgical procedure that may not be covered by your contract. That applies also to Medicare patients.

Let me assure you that I will order tests that I feel are necessary for your treatment and care. If you have any questions about BC-PMD or Medicare, such as whether a particular service is covered or not, someone in our office will be happy to assist you. Thank you very much for your understanding.

_____ Signature	_____ Date	_____ Service that may not be covered, as explained to the patient.
_____ Signature	_____ Date	_____ Service that may not be covered, as explained to the patient.
_____ Signature	_____ Date	_____ Service that may not be covered, as explained to the patient.
_____ Signature	_____ Date	_____ Service that may not be covered, as explained to the patient.
_____ Signature	_____ Date	_____ Service that may not be covered, as explained to the patient.
_____ Signature	_____ Date	_____ Service that may not be covered, as explained to the patient.
_____ Signature	_____ Date	_____ Service that may not be covered, as explained to the patient.
_____ Signature	_____ Date	_____ Service that may not be covered, as explained to the patient.
_____ Signature	_____ Date	_____ Service that may not be covered, as explained to the patient.

I have read your policy, and agree to pay for the services not covered by my contract as indicated by my signature for each date above.

**Consent and Acknowledgment Form**

I hereby consent to the use and disclosure of all Medical Data about me or my minor children for uses allowed by law, including for the following purposes:

1. Review by doctors, hospitals, other health care providers and their staff who treat us;
2. Review by insurers, administrators and others who may pay for the cost of treating us;
3. Review by health care officials when statutes, regulations or professional duty so required.

To facilitate these uses, I authorize the InfoSolutions® Medical Information Network maintained by Blue Cross and Blue Shield of Alabama to collect, store, compile and distribute this Medical Data. I understand my health care providers and Blue Cross protect the data and keep it private to the best of their ability through the use of encryption, passwords and other security measures. I further understand I may: (a) request from InfoSolutions® a list of those entities who have been provided a copy of Medical Data on me and my minor children; (b) obtain a copy of this form; and (c) withdraw this Consent, although my Medical Data can still be used and disclosed in those situations where the law does not require consent.

**A COPY OF THIS FORM WILL BE AS VALID AS THE ORIGINAL.**

\_\_\_\_\_  
Signature of Patient Date  
(Signature of parent or guardian is required for Patients under age 14)

\_\_\_\_\_  
Name of Your Physician

\_\_\_\_\_  
Please Print Name of Patient

\_\_\_\_\_  
Blue Cross and Blue Shield of Alabama  
Contract Number of Patient

\_\_\_\_\_  
Social Security Number of Patient

\_\_\_\_\_  
Birthdate of Patient

\_\_\_\_\_  
Street Address of Patient

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

NAME \_\_\_\_\_

DATE \_\_\_\_\_

In order to comply with privacy law guidelines, we need a list of those friends/family members that we have permission to discuss your medical information, test results, and/or appointment information.

NAME	RELATIONSHIP	PHONE NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

\*\*Do you give permission for the following information to be left on your answering machine or voice mail?

appointment information	_____ yes	_____ no
test results	_____ yes	_____ no
general information	_____ yes	_____ no

SIGNATURE \_\_\_\_\_