

BLUERIDGE SURGICAL CLINIC

Timothy K. Bowers, Jr. MD, FACS

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Winchester, Va. 22601

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Blueridgesurgicalclinicva.com

APPT: _____

PATIENT QUESTIONNAIRE

Patient's Name _____ Birth Date _____

Age: _____ Social Security No. _____ Marital Status _____

Patient's Mailing Address _____

City and State _____

Patient's Physical Address _____

Home Phone No. _____ Occupation: _____

Patient's Employer: _____

Employer's Address: _____

Employer's Phone No.: _____

Name of Spouse or Parent: _____

Spouse's Employer: _____ Phone No.: _____

Name of Primary Care Physician & Address/Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

REFERRED BY: _____

INSURANCE INFORMATION:

Medicare: _____ Medicaid: VA or WV _____

Medical Insurance Company: _____

Address: _____

Subscriber: _____ Relationship to Patient: _____ Birth date: _____

Social Security Number _____ ID No: _____ Group # _____

Second Page Patient Questionnaire:

HIPPA

On this date, I have been given a notice describing how health information about me, as a patient of this practice, may be used and disclosed, and how I can get access to your information. This notice is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability of 1996(HIPPA).

RELEASE OF MEDICAL HISTORY AND ASSIGNMENT OF BENEFITS

I hereby authorize and give permission to Timothy K. Bowers Jr. MD. to release billing and medical information to include the transcript of my medical records to my insurance carrier(s) upon request, for the purpose of determining benefits payable under the contract.

I hereby assign to Timothy K. Bowers Jr. MD. And all benefits incurred for the services provided by them. I understand that I am financially responsible for charges not covered by my insurance. This includes payment of any deductible amount and or any unpaid balance after payment by my insurance carrier(s).

I certify that the information given by me in applying for payment under Title XV111 of the Social Security Act is correct. I authorize any holder of my medical or other information about to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I request that payment or authorized benefits be made in my behalf.

Signature of Patient or Responsible Party

Date

FINANCIAL RESPONSIBILITY

I hereby accept responsibility for payment in full for services provided by Timothy K. Bowers JR. MD. If I cannot pay in full I agree to make monthly payments. In the event I do not meet my financial responsibility with Timothy K. Bowers Jr. MD. I agree to pay cost of collection, including the collection agency and or attorney's fee.

Signature of Patient or Guarantor

Date

T.K. BOWERS, JR. MD
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brsurgeryclinic@aol.com

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY
PRACTICES FOR PROTECTED HEALTH INFORMATION AND RELEASE OF
PATIENT TEST RESULTS/APPOINTMENTS**

I, _____, authorize Dr. T.K. Bowers, Jr., or designee to release routine test results (including, but not limited to laboratory, radiology, pathology) and all other medical information deemed appropriate by physician to:

YES NO pt initials _____ answering machine with identity confirmed

YES NO pt initials _____ spouse: _____

YES NO pt initials _____ other-name: _____

Relationship: _____

Expiration Date: This release does not expire until revoked in writing by the above named patient.

Patient Signature

Date

Revised 041609 dks

Patient Medical Information Form

Patient Name: _____ Referring Physician: _____

Date: _____ Date of Birth: _____

Height _____ Weight _____ EMAIL _____

Do you smoke or use tobacco _____

Do you use alcohol _____

PHARMACY AND PHONE NUMBER: _____

MEDICAL HISTORY: (WHAT YOU HAVE NOW)

| | | |
|---|--|--|
| <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart attack <input type="checkbox"/> Abnormal heart rhythm <input type="checkbox"/> Heart murmur <input type="checkbox"/> Heart valve damage <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema (COPD) <input type="checkbox"/> Breast cancer <input type="checkbox"/> Colon cancer <input type="checkbox"/> Other cancers <input type="checkbox"/> Bleeding tendency <input type="checkbox"/> Gallstones <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Diverticulosis/Diverticulitis <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Ulcerative colitis <input type="checkbox"/> Hepatitis <input type="checkbox"/> Stomach ulcer <input type="checkbox"/> Enlarged prostate <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Kidney stones |
|---|--|--|

HAVE YOU EVER HAD HISTORY OF MRSA? YES—NO (IN THE LAST 2 YEARS)

FAMILY HISTORY:

| | | |
|--|---|---|
| <input type="checkbox"/> Breast cancer <input type="checkbox"/> Stroke <input type="checkbox"/> Colon cancer <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Pancreas cancer | <input type="checkbox"/> Inheritable disease <input type="checkbox"/> Colon polyps <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart disease <input type="checkbox"/> Ovarian cancer | <input type="checkbox"/> Other cancers <input type="checkbox"/> Bleeding disorder <input type="checkbox"/> Anesthesia problems <input type="checkbox"/> Ulcerative colitis |
|--|---|---|

PREVIOUS OPERATIONS:

| | <u>Date</u> | <u>Reason</u> | <u>Hospital</u> |
|----|-------------|---------------|-----------------|
| 1. | _____ | | |
| 2. | _____ | | |
| 3. | _____ | | |

MEDICATIONS:

| <u>Medicine:</u> | <u>Dose:</u> | <u>When you started:</u> |
|------------------|--------------|--------------------------|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

ALLERGIES:

SYSTEMS REVIEW: (HAVE YOU EVER HAD)

| | | |
|---|---|---|
| <u>Constitutional:</u> <input type="checkbox"/> High blood pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Weight Loss/Gain <input type="checkbox"/> Nausea <input type="checkbox"/> Chills <input type="checkbox"/> Night Sweats | <u>Gastrointestinal:</u> <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Stomach ulcers <input type="checkbox"/> Blood in stool <input type="checkbox"/> Black Stool <input type="checkbox"/> Cirrhosis/Hepatitis <input type="checkbox"/> Gallstones <input type="checkbox"/> Jaundice <input type="checkbox"/> Pancreatitis | <u>Vascular</u> <input type="checkbox"/> Blood vessel problems <input type="checkbox"/> Known narrowing of vessels |
| <u>Anesthesia:</u> <input type="checkbox"/> Anesthesia problems <input type="checkbox"/> Trouble waking up <input type="checkbox"/> Nausea and vomiting <input type="checkbox"/> Malignant hyperthermia <input type="checkbox"/> Prior warnings re: anesthesia | <u>Genitourinary:</u> <input type="checkbox"/> Kidney stones <input type="checkbox"/> Urinary infections <input type="checkbox"/> Blood in urine <input type="checkbox"/> Pain/burning with urination | <u>Musculoskeletal:</u> <input type="checkbox"/> Bone or joint pain <input type="checkbox"/> Arthritis <input type="checkbox"/> Gout <input type="checkbox"/> Spinal disc problems |
| <u>Cardiac:</u> <input type="checkbox"/> Chest pains <input type="checkbox"/> Heart attack <input type="checkbox"/> Angioplasty <input type="checkbox"/> Heart failure <input type="checkbox"/> Abnormal heart rhythm <input type="checkbox"/> Heart murmur | | <u>Endocrine:</u> <input type="checkbox"/> Hyperthyroid <input type="checkbox"/> Hypothyroid <input type="checkbox"/> Diabetes <input type="checkbox"/> Insulin |
| | | <u>Hematologic:</u> <input type="checkbox"/> Bleeding problems <input type="checkbox"/> Prior blood clots <input type="checkbox"/> Bruising <input type="checkbox"/> Anemia |

Patient Signature

Date