BLUERIDGE SURGICAL CLINIC

Timothy K. Bowers, Jr. MD, FACS
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Blueridgeherniacenter.com

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**

REVISED: 2/2020 dks

Blue Ridge Surgical Clinic
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NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION AND RELEASE OF PATIENT TEST RESULTS AND RECORDS.

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.

YES NO pt initials____ to leave message on answering machine w/identity confirmed

YES NO pt initials____ spouse:_____

YES NO pt initials____ other name:_____

Relationship: _____

YES NO pt initials____ Consent to sending text messages or emails for appointment reminders.

YES NO pt initials____ Consent to retrieve prescription history when medications are Ordered.

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

_____ _____

Patient Signature Date

Revised 3/2020 dks

Patient Medical Information Form

Patient Name:_____ Referring Physician: _____

Date: _____ Date of Birth: _____

Height_____ Weight_____ Email _____

Do you smoke or use chewing tobacco: (NO or circle one or both)
Do you use alcohol: yes or no
PHARMACY AND PHONE NUMBER:_____

MEDICAL HISTORY: (WHAT YOU HAVE NOW)

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

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

FAMILY HISTORY:

☐ Breast cancer	☐ Inheritable disease	☐ Other cancers
☐ Stroke	☐ Colon polyps	☐ Bleeding disorder
☐ Colon cancer	☐ Diabetes	☐ Anesthesia problems
☐ Crohn's disease	☐ Heart disease	☐ Ulcerative colitis
☐ Pancreas cancer	☐ Ovarian cancer	

PREVIOUS OPERATIONS:

	Date	Reason	Hospital
1.			
2.			
3.			

MEDICATIONS:

	Medicine:	Dose:	When you started:
1.			
2.			
3.			
4.			
5.			

ALLERGIES:

SYSTEMS REVIEW: (HAVE YOU EVER HAD)

Constitutional:
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Fever
- ☐ Stroke
- ☐ Weight Loss/Gain
- ☐ Nausea
- ☐ Chills
- ☐ Night Sweats

Anesthesia:
- ☐ Anesthesia problems
- ☐ Trouble waking up
- ☐ Nausea and vomiting
- ☐ Malignant hyperthermia
- ☐ Prior warnings re: anesthesia

Cardiac:
- ☐ Chest pains
- ☐ Heart attack
- ☐ Angioplasty
- ☐ Heart failure
- ☐ Abnormal heart rhythm
- ☐ Heart murmur

Gastrointestinal:
- ☐ Abdominal pain
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Stomach ulcers
- ☐ Blood in stool
- ☐ Black Stool
- ☐ Cirrhosis/Hepatitis
- ☐ Gallstones
- ☐ Jaundice
- ☐ Pancreatitis

Genitourinary:
- ☐ Kidney stones
- ☐ Urinary infections
- ☐ Blood in urine
- ☐ Pain/burning with urination

Vascular
- ☐ Blood vessel problems
- ☐ Known narrowing of vessels

Musculoskeletal:
- ☐ Bone or joint pain
- ☐ Arthritis
- ☐ Gout
- ☐ Spinal disc problems

Endocrine:
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Diabetes
- ☐ Insulin

Hematologic:
- ☐ Bleeding problems
- ☐ Prior blood clots
- ☐ Bruising
- ☐ Anemia

Patient Signature

Date

Revised 2/2020 dks