PIEDMONT SURGICAL CLINIC
INFORMATION SHEET

DATE:________________________ (PLEASE CIRCLE) Marital Status: S M W D Sep (PLEASE CIRCLE) Sex: M F

FULL NAME ____ SS NO.:______________________
FIRST MIDDLE MAIDEN LAST

ADDRESS OF PATIENT: ____
STREET OR ROUTE NO. AND BOX

CITY:______________________________ STATE: ______________ ZIP:______________

DATE OF BIRTH:____________ AGE: ______ HOME PHONE: ______________CELL PHONE:______________

(PLEASE CIRCLE)
FATHER, MOTHER OR SPOUSE: ______________________________ SS NO.:______________________

I WILL PAY BY: ☐ **CASH** ☐ **CHECK** ☐ **CREDIT CARD (VISA, MC)**

EMPLOYMENT

PATIENT'S PLACE OF EMPLOYMENT: ____

EMPLOYER'S MAILING ADDRESS: ____

WORK PHONE NO.:____

RESPONSIBLE PARTY IF NOT YOURSELF: ____

(PLEASE CIRCLE)
FATHER, MOTHER OR SPOUSE'S PLACE OF EMPLOYMENT: ______________________________

PHONE NO.: ____

EMERGENCY CONTACT

NAME OF NEAREST RELATIVE OR FRIEND, OTHER THAN ABOVE AND LIST A PHONE NO.: ______________________

____

REFERRED BY DR.:______________________ PRIMARY CARE DR.:______________________

WORKMEN'S COMPENSATION

Please complete this section thoroughly. It is very important if we are to file your claims for you.
If this visit concerns a job related accident, when was date of injury?______________________

____

____

INSURANCE INFORMATION

PRIMARY INSURANCE:____
NAME OF INSURANCE POLICY OR CERTIFICATE

POLICYHOLDERS NAME: ______________________ DATE OF BIRTH ______________

SECONDARY INSURANCE:____
NAME OF INSURANCE POLICY OR CERTIFICATE

POLICYHOLDERS NAME: ______________________ DATE OF BIRTH ______________

OTHER INSURANCE:____
NAME OF INSURANCE POLICY OR CERTIFICATE

POLICYHOLDERS NAME: ______________________ DATE OF BIRTH ______________

AUTHORIZATION AND ASSIGNMENT

I hereby authorize G. Giltz Croley, II, M.D., Joseph P. Simpson, M.D., and their associate physicians to furnish protected health information(see our HIPAA Policies and Procedures) to my insurance carriers concerning my illness, treatment, and claim filing. I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.
I understand that if my account is past due and the services of a collection agency are used or a claim is filed with a county court in an attempt to collect this debt, I am solely responsible for the cost of such service.

DATE: ____________SIGNATURE ____

We invite you to discuss further with us any questions regarding our service or fees. The best medical service is based on friendly, mutual understanding between doctor and patient.

G. GILTZ CROLEY, II, M.D. JOSEPH P. SIMPSON, M.D. MARK SANDERS, M.D. MICHAEL A. HOUSTON, M.D.

PATIENT HISTORY

DATE: ______________________

NAME ____ DATE OF BIRTH: ________________

OCCUPATION ____ PHONE ______________________

CHIEF COMPLAINT FOR TODAY'S VISIT? ____

____

ARE YOU ALLERGIC TO ANY MEDICATIONS? (please list) ____________________________________

____

CURRENT MEDICATIONS YOU ARE TAKING ____

____

____

WHERE DO YOU TAKE DIALYSIS? ____

WHAT DAYS? ____

PAST MEDICAL HISTORY

Have you or any member of your family ever had any of the following? (please mark S for self or F for family)

	HIGH BLOOD PRESSURE
	LIVER DISEASE
	HEART ATTACK
	SICKLE CELL ANEMIA
	NERVOUS DISORDERS
	HIGH CHOLESTEROL
	ALCOHOLISM
	MIGRAINE HEADACHES
	CATARACTS
	RHEUMATIC FEVER
	STOMACH DISORDERS
	HEPATITIS
	ANEMIA

	BLEEDING DISORDERS
	KIDNEY DISEASE
	THYROID DISEASE
	EPILEPSY
	CANCER
	TUBERCULOSIS
	MENTAL ILLNESS
	ALLERGIC DISORDERS
	EMPHYSEMA
	GLAUCOMA
	ULCERS
	CHRONIC LUNG DISEASE
	HIV

	PHLEBITIS
	ASTHMA
	ANGINA
	SEIZURES
	STROKE
	DEPRESSION
	DIABETES
	ARTHRITIS
	ANXIETY
	HEART MURMUR
	CONGESTIVE HEART FAILURE
	MRSA

OTHER ILLNESSES ____

____

WHAT SURGERIES HAVE YOU HAD? ____

____

____

PERSONAL HABITS:

SMOKE YES ________ NO __________ HOW MUCH A DAY?

ALCOHOL YES ________ NO __________ HOW MUCH A DAY?