PATIENT REGISTRATION-2015

Name_____
First Last MI

Address_____
Street City State Zip

Preferred Phone Number_____ Secondary Phone Number_____
Circle Home/Work/Mobile Circle Home/Work Mobile

Date of Birth_____/____/_____ Age_____Gender M/F Social Security #_____(Insurance Only)

Marital Status: S M D W (Circle) Emergency Contact_____
Name Phone Relationship

Parent/Guardian (if child):_____
Name Relationship

Reason for visit _____ Email_____

May we leave voicemails on at Primary or Secondary Phone Numbers? Circle one: Primary or Secondary

For appointment reminders, do you prefer a phone call or email? Circle one: Phone Email

How did you hear about us? Circle one or more: Physician Friend Hospital Internet Website Other_____

Health Insurance Info: **Does not apply to cosmetic surgery or medical spa patients.**

Please provide office with current insurance card. If patient is not primary subscriber, please provide the following:

_____
Primary' Subscriber's Name Date of Birth Social Security Number
Insurance claims cannot be processed without this information.

PRIVACY RELEASE
I authorize the release of medical information to my primary care or referring physician, to consultants and as necessary to process insurance claims and prescriptions. I also authorize payment of medical benefits to the physician.

ASSIGNMENT OF BENEFITS
I hereby instruct and direct _____ insurance company to pay NW Tampa Surgical Associates (NWTSA) directly for all professional and/or medical expenses rendered by Dr. Aguiar at 12015 Whitmarsh Lane, Tampa FL 33626. I authorize NWTSA and Dr. Aguiar to file a complaint, for any reason with the insurance commission on my behalf.

FINANCIAL POLICY AND CANCELLATION POLICY
Payment is due at time of service unless you have health insurance plan in which physician participates; for those patients, copays, deductibles, and coinsurance will be collected. You will be responsible for any balance not covered by insurance. You are responsible for knowing your deductible and whether or not it has been met. We accept payment in the form of cash or credit/debit card. NO checks. If your account is transferred to collections, you will be charged a collection fee. We required 24 hours notice for cancellations or you will be charged $25. We reserve the right to discharge patients for frequent no-shows and last minute cancellations. Your signature below signifies your understanding of this policy.

Patient or Guardian_____ Date_____

MEDICAL HISTORY

NAME:_____DOB: _____

Past Medical History:

acid reflux	O Yes	O No
heart attack	O Yes	O No
stroke	O Yes	O No
hypertension	O Yes	O No
diabetes, type I	O Yes	O No
diabetes, type II	O Yes	O No
arthritis	O Yes	O No
gout	O Yes	O No
seizures	O Yes	O No
depression	O Yes	O No
anxiety	O Yes	O No
kidney stones	O Yes	O No
cancer, any	O Yes	O No
bleeding problems	O Yes	O No
alcoholism	O Yes	O No
drug abuse	O Yes	O No
anemia	O Yes	O No
stomach ulcers	O Yes	O No
gallstones	O Yes	O No
hypothyroidism	O Yes	O No
hyperthyroidism	O Yes	O No
AIDS/HIV	O Yes	O No

Please explain all YES answers:

_____
_____
_____
_____
_____
_____
_____
_____

Please list additional illness or condition._____
_____
_____
_____
_____
_____

Surgical History: (Please list all surgical procedures – medical and cosmetic)

Procedure	Date

Medication	Dosage	Frequency

Reading Glasses	O Yes	O No
Change of Vision	O Yes	O No
Decreased hearing	O Yes	O No
Ear pain	O Yes	O No
Sore throat	O Yes	O No
Nosebleed	O Yes	O No
Difficulty swallowing	O Yes	O No
Cough	O Yes	O No
Shortness of breath	O Yes	O No
Chills or Fever	O Yes	O No
Chest pain	O Yes	O No
Irregular heartbeat	O Yes	O No
Palpitations	O Yes	O No
Swelling in hands/feet	O Yes	O No
Calf cramps with walking	O Yes	O No
Abdominal pain	O Yes	O No
Blood in stool	O Yes	O No
Constipation	O Yes	O No
Diarrhea	O Yes	O No
Heartburn	O Yes	O No
Weight gain/loss	O Yes	O No
Vomiting	O Yes	O No
Sleep disturbance	O Yes	O No
Night sweats	O Yes	O No
Lightheadedness	O Yes	O No
Headache	O Yes	O No
Blood in urine	O Yes	O No
Difficulty urinating	O Yes	O No
Frequent urination	O Yes	O No
Painful urination	O Yes	O No
Dizziness	O Yes	O No
Fainting	O Yes	O No
Seizures	O Yes	O No
Pain/cramping in legs	O Yes	O No
Anxiety	O Yes	O No
Depressed mood	O Yes	O No
Nervous breakdown	O Yes	O No
Asthma	O Yes	O No
Tuberculosis	O Yes	O No
Wheezing	O Yes	O No
Eczema	O Yes	O No
Hives	O Yes	O No
Itching	O Yes	O No
Rash	O Yes	O No

Women Only

Breast lump	O Yes	O No
Discharge from the breast	O Yes	O No
Heavy bleeding during menses	O Yes	O No
Hot flashes	O Yes	O No
Irregular menses	O Yes	O No
Vaginal discharge/itching	O Yes	O No

Review of Systems

Please indicate if you are experiencing any of the following symptoms now or in the recent past.

Drug Allergies:

Please list any medications that you are allergic too. Also include items such as Latex, medical tape etc.

_____

_____

_____

_____

_____

_____

Please explain all YES answers. Use back of sheet if necessary.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

SOCIAL & FAMILY HISTORY

Social History

Tobacco Use: O Yes O No O Never _____#packs/day
How often do you drink alcohol? O Never O Occasionally O Moderate to Heavy
History of Domestic Abuse? O Yes O No
Drug Overuse? O None O Present O Past Problem
Number of Pregnancies O 1 O 2 O 3 O 4 O 5 O 6 O other
Number of Living Children O 1 O 2 O 3 O 4 O 5 O 6 O other

Race:_____ Ethinicity:_____ Primary Language:_____

Most recent occupation:_____

Family History *(Please only mark areas that pertain. If NO family members have illness, leave blank.)*

stroke O mother O father O sibling O m-grandmother
O m-grandfather O p-grandmother O p-grandfather O other
heart trouble O mother O father O sibling O m-grandmother
O m-grandfather O p-grandmother O p-grandfather O other
High Blood Pressure O mother O father O sibling O m-grandmother
O m-grandfather O p-grandmother O p-grandfather O other
diabetes O mother O father O sibling O m-grandmother
O m-grandfather O p-grandmother O p-grandfather O other
arthritis O mother O father O sibling O m-grandmother
O m-grandfather O p-grandmother O p-grandfather O other
gout O mother O father O sibling O m-grandmother
O m-grandfather O p-grandmother O p-grandfather O other
seizures O mother O father O sibling O m-grandmother
O m-grandfather O p-grandmother O p-grandfather O other
mental Illness O mother O father O sibling O m-grandmother
O m-grandfather O p-grandmother O p-grandfather O other
kidney stones O mother O father O sibling O m-grandmother
O m-grandfather O p-grandmother O p-grandfather O other
cancer O mother O father O sibling O m-grandmother
O m-grandfather O p-grandmother O p-grandfather O other
bleeding problems O mother O father O sibling O m-grandmother
O m-grandfather O p-grandmother O p-grandfather O other
alcohol or drug abuse O mother O father O sibling O m-grandmother
O m-grandfather O p-grandmother O p-grandfather O other

Hospitalization: (Have you ever been in the hospital overnight?)

Reason for Hospitalization	***Date***