platinum SURGICAL CARE

Gregg A. Ginsburg MD, FACS
Phone: 636-931-4744
Toll Free: 877-931-4744

Name: _____ Date of Birth: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Marital Status: _____

Social Security #: _____ Email Address: _____

Employer: _____ Employer Phone: _____

Name of Emergency Contact: _____ Relationship: _____
Phone Number: _____ Address: _____

Primary Care Physician: _____ Referring Physician: _____

Primary Insurance: _____ ID Number: _____
Cardholder's Name: _____ Cardholder's Social Security #: _____
Relationship to Patient: _____ Cardholder's Date of Birth: _____
Cardholder's Employer: _____

Secondary Insurance: _____ ID Number: _____
Cardholder's Name: _____ Cardholder's Social Security #: _____
Relationship to Patient: _____ Cardholder's Date of Birth: _____
Cardholder's Employer: _____

I hereby authorize my insurance benefits, to be paid directly to Gregg A. Ginsburg, MD. I understand that I am financially responsible for all charges, whether or not paid by said insurance. I also understand that failure to provide proper insurance information or obtain any required insurance plan referrals will result in my acceptance of full financial responsibility for these services. Copayments will be due at the time of service. I hereby authorize said assignee to release all information necessary to secure that payment. In the event this account is assigned to collections, I agree to pay all cost of collection including reasonable attorney fees. It is the policy of Platinum Surgical Care to provide services to all persons without regard to race, color, national origin, religion, sex, age or disability. For bariatric patients, if my insurance plan(s) excludes bariatric benefits, I understand that no insurance claim will be submitted to my insurance carrier(s). Fees associated with office visits and procedures for the treatment of obesity will be my financial responsibility.

Signature of Patient or Parent/Guardian: _____ **Date:** _____

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Patient Medical History Form

Patient Name: _____ **Date of Birth:** _____

CURRENT MEDICATIONS	DOSE	FREQUENCY	REASON FOR TAKING

*If necessary, please continue listing medications on bottom of next page.

ANY MEDICATION ALLERGIES? Yes No If yes, be specific _____

IMMUNIZATIONS: Influenza (flu): Yes No Date: _____ Pneumococcal: Yes No Date: _____

MEDICAL HISTORY

_____
_____
_____

PLEASE LIST ANY PREVIOUS SURGERIES/HOSPITALIZATIONS

_____
_____

Female Patient's: Date of last Mammogram: _____ Normal Abnormal (circle one)

Colonoscopy within 10 years: Yes No Date: _____ Physician: _____
Where was it done? _____ Results: _____

Any falls within the past year? Yes No # of falls _____ Injuries? _____

PATIENT SOCIAL HISTORY:

Are you a: Current Smoker ___ Former Smoker ___ Never a smoker ___ When did you start? _____

Packs per day _____ Do you smoke: Everyday ___ Some days, but not everyday ____

When did you quit? _____ Are you interested in quitting? Yes No

Recreational Drug Use? Yes No Alcohol Use? Never Rarely Moderately Daily

Caffeine Consumption: Yes No If yes, please explain: _____

FAMILY MEDICAL HISTORY:

	AGE	**Please list health history**	**If deceased, cause of death**
Father:	_____	_____	_____
Mother:	_____	_____	_____
Siblings:	_____	_____	_____
	_____	_____	_____
Children:	_____	_____	_____

Authorization to Access RX History information: I hereby authorize Platinum Surgical Care to access my historical prescription drug information. Without this authorization we will not be able to prescribe any controlled substances to you.

Patient Name: _____ Signature: _____ Date: _____

Preferred Pharmacy: _____ Phone Number: _____

Location or address of pharmacy: _____

Preferred Laboratory/Radiology Facility to be used for tests/labs: _____

Location: _____

The following information is now being required for Healthcare/Government reporting purposes. **Please complete all 3 required questions listed below.**

Race: Asian Black or African American Caucasian Hispanic American Indian or Alaskan Native Other _____

Language: English Indian Spanish Other _____

Ethnicity/Nationality: Hispanic Non-Hispanic Other _____

Patient Name: _____ **Date of Birth**: _____

CONSTITUTIONAL SYMPTOMS

Good general health lately	No	Yes
Recent Weight Change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

EYES

Eye disease or injury	No	Yes
Wear glasses/contact lens	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes

EARS, NOSE & THROAT

Hearing loss or ringing	No	Yes
Earaches or draining	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

CARDIOVASCULAR

Heart disease	No	Yes
Shortness of breath with		
Walking or lying flat	No	Yes
Hypertension	No	Yes
Chest Pain or Angina Pectoris	No	Yes
Palpitations	No	Yes

RESPIRATORY

Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

GASTROINTESTINAL

Loss of appetite	No	Yes
Change in bowel movement	No	Yes
Nausea or Vomiting	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain	No	Yes

BREAST

Breast discharge	No	Yes
Breast pain	No	Yes
Breast Lump	No	Yes

NEUROLOGICAL

Frequent headaches	No	Yes
Lightheaded or dizzy	No	Yes
Convulsions/seizures	No	Yes
Numbness/tingling sensation	No	Yes
Stroke	No	Yes
Head Injury	No	Yes

ENDOCRINE

Glandular/Hormone problems	No	Yes
Thyroid disease	No	Yes
Diabetes	No	Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	No	Yes
Bleeding/bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

GENITOURINARY

Frequent urination	No	Yes
Burning/painful urination	No	Yes
Blood in urine	No	Yes
Kidney stones	No	Yes
Urinary incontinence	No	Yes

CURRENT HEIGHT: _____

CURRENT WEIGHT: _____

Are you interested in speaking with Dr. Ginsburg regarding diet & exercise? Yes or No (circle one)

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1455 Highway 61, Suite B; Festus, MO 63028 Fax#: 636-931-4739

AUTHORIZATION FORM FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE SIGN AND DATE ONLY, OUR OFFICE WILL COMPLETE DOCUMENT IF NEEDED

Name: _____ Date of Birth: _____

I hereby authorize _____to obtain or release protected health information, including any sensitive information, for the purposes described below.

Description of the specific information to be obtained or released: _____

_____

The persons in our workforce authorized to make the disclosure is: Medical Records Dept.

The person or entity to whom we will disclose the information, and who may use it, are:

_____

The purpose for which the use/disclosed information will be used:

_____

You may refuse to sign this authorization. Your refusal will NOT affect your ability to obtain treatment, payment or eligibility for benefits. If the persons who are authorized to receive the information above are NOT health care providers or health plans covered by federal health privacy laws, they may re-disclose that information and those laws would no longer protect it.
You may inspect or copy the protected health information to be used or disclosed under this authorization. Please send your request to our office at 1455 Highway 61, Suite B, Festus, MO 63028. Once you give us this authorization, we can rely on it until you revoke it or, if you have not revoked it, until it expires. You can revoke this authorization by delivering a dated and signed letter to our office. However, your revocation will not prohibit us from

a. Any acts we have already taken in reliance of the authorization, or
b. Any right associated with an insurer's contest of a claim under its policy, if the authorization was obtained in order to obtain insurance coverage. If not revoked, this authorization will expire one year from the date of the signature below.

X_____ Date: _____

Signature of (Patient or Legal Representative) Capacity of Legal Rep. _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. Obtain payment from third-party payers. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses of and disclosures of my health information which is posted in the waiting room, on our website, and available upon my request. I understand that this organization has the right to change its Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

PRINTED PATIENT NAME: _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____

DATE: _____

To address any special needs you may have and to assure your patient information is kept confidential please answer the following questions.

Other than yourself, do you authorize our office to discuss your health information with a family member or spouse?
Circle One YES NO

If so, please list names below for our record

NAME: _____ **RELATIONSHIP:** _____

NAME: _____ **RELATIONSHIP:** _____

NAME: _____ **RELATIONSHIP:** _____

Do you authorize our office to call your home and leave a message about test results, appointments?
Circle One YES NO

Do you authorize our office to call you at work?
Circle One YES NO

OFFICE USE ONLY: I attempted to obtain the patient's signature on this Notice but was unable to do so as documented below:
Reason: _____ **Staff Initials:** _____ **Date:** _____