Patient Information Sheet

Name (Last): _____ First: _____ Middle Initial: _____

Date of Birth: _____ Age: _____ Sex: Male or Female (circle one)

Social Security Number: _____ Marital Status: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Alternate Phone: _____

Place of Employment: _____ Phone: _____

Spouses Name: _____ Phone: _____

Spouses Employment: _____ Phone: _____

Emergency Contact (not living with you): _____

Relationship: _____ Phone: _____

Insurance Information

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Subscriber's Social Security Number: _____ Relationship to Patient: _____

In order for your insurance to be filed by this office we must have your signature for our file. Please sign the authorization below.

I hereby authorize the payment of medical benefits to be made directly to Metro Surgical, PC for services rendered to myself or my dependents. I understand that I am responsible for making sure that the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I agree to make arrangements for prompt payment.

I authorize Metro Surgical, PC physicians to examine me and render medical or surgical care as he/she deems necessary.

I authorize any holder of medical or other information about me, to release to the Social Security Administration and Center for Medicare and Medicaid Services (CMS; formerly HCGA) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 USC 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Signature: _____ Date: _____

Patient History & Physical

Patient Name: _____ Age: _____ Height: _____ Weight: _____

Reason for visit:
_____

List all medications currently taking:
_____
_____

List any drug allergies:
_____
_____

List any operations and when they took place:
_____
_____
_____

Have you ever been hospitalized for reasons other than surgery? Please describe:
_____
_____

List any diseases that run in your family:
_____
_____

Do you smoke? Yes or No
Former Smoker? Yes or No Quit MM/YY:_____
Do you drink alcohol? Yes or No
How often? _____

Pharmacy Name & Telephone:
_____

Have you traveled outside of the U.S. within the last 12 months? Yes or No If yes, when? _____

Have you received a flu vaccine? Yes or No If yes, when? _____

Have you received a pneumonia vaccine? Yes or No If yes, when? _____

Have you received the COVID-19 vaccine(s)? Yes or No If yes, when? _____

*Brand of COVID-19 vaccine(s) received; i.e., Moderna, Pfizer, etc. _____

Have you had or do you presently have any of the following conditions? Please circle any that apply.

Aids or HIV	Heart Disease	Irregular Heart Beat	Cancer
Lung Disease	High Blood Pressure	Tuberculosis	Muscle Disease
Bleeding Tendency	Pneumonia	Nervous Condition	Stomach Disease
Intestinal Disease	Epilepsy	Kidney Disease	Rheumatic Fever
Hepatitis	Liver Disease	Anemia	Pregnancies # _____

Family History:

Relationship	Age	Living	Dead	Cause of Death	Major Disease
Father					
Mother					
Brother					
Sister					

Is there anything else you feel the doctor should know? Please describe: _____
_____

Signature: _____ Date: _____

Colonoscopy Insurance Statement

Please be advised every insurance company is different. While we do our best to verify your benefits, it is your responsibility to know your insurance policy and benefits. Many insurance companies offer SCREENING colonoscopies covered at 100%. By circling any of the following symptoms your colonoscopy will be considered a diagnostic colonoscopy and not a screening. If you are scheduled to have a routine screening colonoscopy and your surgeon discovers any polyps, masses, etc. and/or performs biopsies—YOUR INSURANCE may consider the procedure to be diagnostic, rather than a screening, which could affect the covered benefit amount.

Circle any that CURRENTLY apply:

Rectal pain	Rectal bleeding	Rectal discharge
Diarrhea	Constipation	Change in bowel habits
Nausea	Vomiting	Fever
Abdominal pain	Unexplained weight loss	Blood in stool

Personal / Family History:

Personal history of colon polyps

Personal history of colon cancer

Personal history of Crohn's Disease

Personal history of Ulcerative Colitis

Family history of colon polyps (**Circle any applicable**) Mother Father Brother Sister

Family history of colon cancer (**Circle any applicable**) Mother Father Brother Sister

Complete if previously performed:

Colonoscopy MM/YYYY: _____ Results: _____

Flexible Sigmoidoscopy MM/YYYY: _____ Results: _____

Barium Enema MM/YYYY: _____ Results: _____

By signing below, you are agreeing to pay for any services and/or charges that are not covered by your insurance plan (including amounts applied toward your deductible).

_____ _____

Print Patient Name Date of Birth Patient Signature Date

Patient Consent for Use/Disclosure of Health Care Information

Patient name: _____ Date of birth: _____

SSN: _____ Previous name: _____

I understand that the patient's health information is private and confidential. I understand that Metro Surgical, PC works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Metro Surgical, PC may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

Metro Surgical, PC has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the notice before signing this agreement.

Metro Surgical, PC may update this "Notice of Privacy Practices". If I ask, Metro Surgical, PC will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask Metro Surgical, PC to limit how the patient's personal health information is used or disclosed to carry out treatment, payment or other health care operations. I understand Metro Surgical; PC does not have to agree with my request. If Metro Surgical, PC does agree to my request, I understand Metro Surgical, PC would follow the agreed limits.

I may cancel this consent in writing at any time by doing one of the following:

1. Signing and dating a form that Metro Surgical, PC can give me called "Revocation of Consent for Use and Disclosure of Health Care Information"; or

2. Writing, signing, and dating a letter to Metro Surgical, PC. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, and health care operations.

If I revoke this consent, Metro Surgical, PC does not have to provide any further health care services to the patient.

My signature below indicates that I have been given the opportunity to review a current copy of Metro Surgical, PC's "Notice of Privacy Practices". My signature means that I agree to allow Metro Surgical, PC to use and disclose the patient's personal health information to carry out treatment, payment, and health care operations.

_____ _____ _____

Patient or legally authorized individual signature | Date | Time

_____

Relationship to patient (If signed by legal representative)

Patient Record of Disclosure

In general, the HIPAA privacy rules give the individuals the right to request a restriction on uses and disclosures of protected health information and electronic protected health information.

I wish to be contacted in the following manner (please check all that apply).

____ Home Phone _____

____ Leave a message with detailed information

____ Leave a message with callback number only

____ Cell Phone _____

____ Leave a message with detailed information

____ Leave a message with callback number only

____ Work Phone _____

____ Leave a message with detailed information

____ Leave a message with callback number only

____ Written Communication

____ Mail to my home address

____ Mail to my work address

____ E-Mail address: _____

You may leave a message with, discuss my treatment, appointment, or other scheduling that may occur with the following family, friend or personal representative(s). I understand that by giving authorization to the representative(s) listed below, they will have complete access to my electronic medical record. I understand Metro Surgical, PC will refuse to discuss my information with anyone **not** listed below, except in emergency. I also understand that this consent does not apply to medical providers.

PLEASE PRINT (family, friend or personal representative(s))

1. Name: _____ Phone: _____

2. Name: _____ Phone: _____

_____ _____

Print Patient Name Date of Birth Patient Signature Date

FollowMyHealth Online Registration Form

Access your medical information on the go! Download the free portal app at your Apple or Android store. FollowMyHealth is not monitored by staff members. If you have any questions or concerns, please contact our office at (912) 826-4057. Do not send any messages through the portal, we will not see it.

Check one:

☐ I decline account access on the FollowMyHealth online application for Metro Surgical, PC.

☐ I wish to set up account access on the FollowMyHealth online application for Metro Surgical, PC. ***I understand the portal is not monitored daily and agree to contact the office via telephone with any questions or concerns***. My email address (required for access) is:

_____@_____

Print Patient Name Date of Birth Patient Signature Date