CENTRAL SURGICAL
ASSOCIATES, PLLC

Patient Information **PLEASE USE INK ONLY** **NO PENCILS PLEASE**

Patient Name_____
LAST First Middle

Date of Birth _____Age _____ Sex ( ) Male ( ) Female

Social Security _____ ( ) Married ( ) Single ( ) Divorce ( ) Separated ( ) Widowed

Please use your physical mailing address

Patient Mailing Address: _____Apt:_____

City_____ State_____ Zip_____

Home Phone ( ) _____ Cell Phone ( ) _____

Patient Employment_____ Business Phone_____

Patient Email Address _____

Spouse Name_____ Spouse Date of Birth_____
Last First Middle

Spouse Social Security #_____

Spouse Employment _____ Spouse Employment Phone _____

Primary Health Insurance Company_____
Policy Number_____ Group Number_____
Primary Policy Holder_____ Date of Birth_____
Last First Middle

Secondary Health Insurance_____
Policy Number_____ Group Number_____
Primary Policy Holder_____ Date of Birth_____
Last First Middle

Name of person responsible for this account: _____

Relationship to patient _____

Contact # _____ DOB _____SS#_____

Address _____

Emergency Contact_____ Relationship _____

Home Phone _____ Work _____Cell _____

Pharmacy Information

Preferred Pharmacy:_____Location:_____Phone:_____

Please Check Ethnicity Information

Black or African American		Hispanic/ Latino		English	
White		Non-Hispanic/Latino		French	
American Indian Alaska Native		Refuse to Report		German	
Native Hawaiian/Pacific Island				Japanese	
Other				Spanish	

Billing and Insurance Claims:

- IT IS THE PATIENT'S RESPONSIBILITY TO NOTIFY US OF ANY INSURANCE REQUIREMENTS: PRE-CERT, SECOND OPINION, REFERRAL NUMBERS, CO-PAYS, X-RAYS, LAB PREFERENCE OR HOSPITAL PREFERENCE PER YOUR INSURANCE CARRIER.

- DENIAL OF CLAIMS OR UNPAID BILLS DUE TO INCORRECT INFORMATION WILL BE THE PATIENTS RESPONSIBILITY.

CENTRAL SURGICAL ASSOCIATES, PLLC CANNOT AND WILL NOT CHANGE PHYSICIAN DIAGNOSIS TO COVER NON-COVERED SERVICES. IF YOU FEEL THERE IS AN ERROR IN YOU MEDICAL RECORD YOU MAY PUT IN A REQUEST AND OUR MEDICAL RECORDS DEPARTMENT WILL LOOK AT IT AND DETERMINE IF YOUR REQUEST IS VALID.

PATIENT/GUARDIAN BY SIGNING BELOW YOU ARE RESPONSIBLE FOR ANY CO-PAYMENTS UN-MET DEDUCTIBLES AND ANY UN-PAID PORTION OF THE BILL.

Disability/FMLA Forms:

- I UNDERSTAND THAT ANY ADDITIONAL CLAIM FORMS SUCH AS ATTENDING PHYSICIAN STATEMENTS OR DISABILITY FORMS THAT CENTRAL SURGICAL ASSOCIATES, PLLC FILLS OUT FOR ME, WILL ONLY BE FILLED OUT ON FRIDAYS AND I WILL BE CHARGED $ 10.00 PER FORM DUE WHEN FORMS ARE PICKED UP, MAILED OR FAXED.
- FAMILY MEDICAL LEAVE (FMLA) FORMS ARE FILLED OUT AT A NO CHARGE TO THE PATIENT AND WILL BE FILLED OUT ON FRIDAY'S ONLY.

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFITS:

BY SIGNING THIS FORM, I AUTHORIZE:

- CENTRAL SURGICAL ASSOCIATES, PLLC, NURSE, PHYSICIAN OR PHYSICIAN ASSISTANT TO TREAT ME.
- I FURTHER AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY FOR THE COMPLETION OF-- (TPO) TREATMENT, PAYMENT OR OPERATIONS.
- I AUTHORIZE PAYMENT DIRECTLY TO CENTRAL SURGICAL ASSOCIATES, PLLC AND THE TREATING PHYSICIAN FOR ALL MEDICAL BENEFITS OTHERWISE PAYABLE TO ME UNDER THE TERMS OF MY INSURANCE.
- I UNDERSTAND THAT WHILE I AM UNDER CENTRAL SURGICAL ASSOCIATES, PLLC/PHYSICIAN TREATMENT IT IS ALSO MY RESPONSIBILITY TO NOTIFY CENTRAL SURGICAL ASSOCIATES, PLLC OF ANY CHANGES. SUCH AS ADDRESS CHANGE, PHONE NUMBER, INSURANCE, JOB, OR MARITAL STATUS. IT IS ALSO MY RESPONSIBILITY TO MAKE SURE CENTRAL SURGICAL ASSOCIATES; PLLC HAS A CORRECT COPY OF MY INSURANCE CARD(S).

CENTRAL SURGICAL ASSOCIATES, PLLC WILL FILE YOUR INSURANCE CLAIM FOR YOU. HOWEVER, YOU ARE RESPONSIBLE FOR MAKING SURE CLAIMS ARE PAID.
A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I HAVE READ THE ABOVE AND UNDERSTAND MY RESPONSIBILITIES.

Patient/Guardian Signature:_____**Relationship:**_____

Date:_____

CENTRAL SURGICAL
ASSOCIATES, PLLC

❖ Patient Name: _____

Please Circle:
Which physician are you seeing today: Fiser, Hamilton, Jones, Logan, Nicols, or Rooks

Reason for visit: _____
Symptoms/Complaints: _____
How long have you had this complaint? _____
Referring Physician: _____Family Physician: _____

PAST MEDICAL HISTORY (please check all that apply)

Aids/HIV		Hepatitis	
Asthma		High Blood Pressure	
Blood Clots		High Cholesterol	
COPD		Kidney Disease	
Diabetes		Jaundice	
Heart Attack		Seizures	
Heart Disease		Stroke	
Cancer (type): Year Diagnosed:			
Other:			

Tobacco	Never	Current	Former	Packs Per Day	# Years
Cigarettes					
Smokeless					

Alcohol	Never	Occasional	Daily	Drinks per day

Controlled Substances(Drugs)	Never	Occasional	Daily	Type Used

Family History

Heart attack	Stroke	High Blood Pressure	Diabetes	Cancer	Type
☐Mother	☐Mother	☐Mother	☐Mother	☐Mother	_____
☐Father	☐Father	☐Father	☐Father	☐Father	_____
☐Brother	☐Brother	☐Brother	☐Brother	☐Brother	_____
☐Sister	☐Sister	☐Sister	☐Sister	☐Sister	_____

Other:

CENTRAL SURGICAL
ASSOCIATES, PLLC

❖ Patient Name: _____

SURGICAL HISTORY ***Please check all that apply and circle right or left as it applies.***

Appendectomy		Mastectomy Right or Left or Both	
Colon Surgery		Lumpectomy Right or Left or Both	
Thyroid Removal		Hemorrhoidectomy	
Heart Surgery		Kidney Transplant	
Hysterectomy		Hiatal Hernia Repair	
EGD (throat scope)		Incisional Hernia Repair	
Colonoscopy		Umbilical Hernia Repair	
Gastric Bypass		Inguinal Hernia Repair R or L or Both	
Gallbladder Surgery		Other:	
Prostate Surgery		Other:	

List Medications "Currently Using" over the counter or prescribed

Medication	Dose	Times per day	Medication	Dose	Times per day

Use back page if you need more space

Medication Allergies:

Penicillin		Lidocaine	
Cipro		General Anesthesia	
Bactrim		IVP DYE (X-ray dye)	
Doxycycline		Silver Products	
Clindamycin		Sulfa	

Please list any other allergies: _____

_____

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❖ **Patient Name: _____**

Have you had a mammogram within the last year?
☐ No
☐ Yes, Date: _____ Location: _____

Do you see a Cardiologist (heart doctor)? If so, Dr_____
Do you see a Pulmonologist (lung doctor)? If so, Dr_____

Dialysis Patients Only
Days you dialyze: ☐Monday/Wednesday/Friday ☐Tuesday/Thursday/Saturday
Dialysis Unit Name/Location: _____
Dialysis Time: _____ Unit Phone #: _____

Workman's Compensation Only

Are you being seen for a work-related accident? ☐YES ☐NO
Have you reported the accident/injury to Workman's Compensation? ☐YES ☐NO
Date of accident/injury: _____
Describe accident/injury: _____
_____
_____

I authorize Central Surgical Associates, PLLC to discuss my medical conditions and care with the following person(s):

1. _____Relationship_____
2. _____Relationship_____
3. _____Relationship_____

Do you have a person who can make medical decisions on your behalf if you are unable to?

YES ☐ NO ☐

If so, Name: _____Relationship: _____

Please rate your pain using the chart below

CENTRAL SURGICAL
ASSOCIATES, PLLC

Central Surgical Associates, PLLC Authorization for Release, Use, and Disclosure of Health Information

Date:_____

I. **PATIENT.** Patient's Name: _____ Date of Birth:_____
Social Security Number:_____

II. **AUTHORIZATION.** I authorize (select one):

☐ Central Surgical Associates, PLLC to disclose my health information to the following:
Name:_____ Phone:_____

☐ The following entity to disclose my health information to Central Surgical Associates, PLLC:
Name:_____ Phone:_____

Please select all that apply:

☐ Complete Medical Records ☐ Discharge Summary ☐ Operative and Procedure Reports
☐ Consultation Reports ☐ Laboratory Results ☐ X-ray and Imaging Results
☐ Pathology Results ☐ Clinical and Progress Notes ☐ Billing Records
☐ Other (list specific items):_____
Hereinafter known as "Medical Records".

III. **DELIVERY.** Please select one of the following:

☐ I will pick up copies of my records
☐ Fax my records to:_____
☐ Mail copies of my records to the following: _____

IV. **PURPOSE.** The reason for this authorization is: (check one)

☐ Personal ☐ Legal/Attorney ☐ Insurance ☐ Disability ☐ Continuing Care ☐ School ☐ Worker's Compensation
☐ Other (be specific):_____

V. **SENSITIVE INFORMATION RELEASE**

I understand that this health information may include sensitive information. By signing this form, I specifically authorize the release of each initialed sensitive information item:

___Substance Abuse Treatment Information ___Mental Health Information ___Genetic Testing
___HIV related information (including AIDS related testing)

VI. **ACKNOWLEDGEMENT OF RIGHTS.**

I understand that unless the purpose of this authorization is to determine payment of a claim or benefits, Central Surgical Associates may not condition the provision of treatment or payment for my care on my signing this authorization. I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance. If you wish to take your permission away, please send a written notice with signature to Central Surgical Associates, PLLC 1190 North State Street, Suite 502, Jackson, MS 39202. I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the Federal privacy regulations. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I understand that I am entitled to receive a copy of this form after I sign it. A copy of this authorization is as valid as the original.

VII. **SIGNATURE.**

I have carefully read and understand the Patient's Rights above, and do herein expressly and voluntarily authorize the disclosure of all the information requested in this authorization including the "Sensitive Information Release". I acknowledge this authorization with my signature below.

Signature of Patient/Representative: _____ Date:_____
Print Name: _____ Relationship to Patient:_____

If the patient listed above is under the age of 18, this authorization form and any revocation must be signed by a parent, guardian, or other person who has the authority to act on the behalf of minor. As the person signing for the patient, I, the parent, guardian, or legal representative warrant that I have the legal authority to act on behalf of the patient and that I am not prohibited by Court order or law from having access to the requested medical records.