Jay S. Stauffer, M.D. / Hill Country General & Oncology Surgery Associates
P.O. Box 2409, Fredericksburg, Texas 78624 Office 830-997-8833 Fax 830-990-8725

PATIENT INFORMATION

NAME _____ SOCIAL SECURITY _____
LAST FIRST MIDDLE INITIAL

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE (___) _____ CELL PHONE (___) _____ WORK PHONE (___) _____

EMAIL ADDRESS (will not be used without patient permission) _____

COMMUNICATION PREFERENCE: ☐ Letter ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Email

BIRTHDATE ____/____/____ AGE _____ GENDER ☐ Male ☐ Female Language Preferred _____

MARITAL STATUS ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor

RACE ☐ White ☐ Hispanic ☐ Black ☐ Native American ☐ Asian ☐ Other

EMPLOYER _____ OCCUPATION _____

WORK ADDRESS _____ CITY _____ STATE _____ ZIP _____

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

NAME _____ SOCIAL SECURITY _____
LAST FIRST MIDDLE INITIAL

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE ( ) _____ CELL PHONE ( ) _____ WORK PHONE ( ) _____

BIRTHDATE ____/____/____ AGE _____ RELATIONSHIP TO PATIENT _____

EMERGENCY CONTACT INFORMATION

NAME _____ PHONE _____

PHYSICIAN REFERRAL INFORMATION

PRIMARY CARE PHYSICIAN _____ REFERRING PHYSICIAN _____

PHARMACY INFORMATION

NAME OF PHARMACY _____ PHARMACY LOCATION (NAME OF TOWN) _____

MEDICAL INSURANCE INFORMATION
PLEASE INCLUDE COPY OF INSURANCE CARDS AND PHOTO ID

NAME OF PRIMARY INSURANCE CO _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

IDENTIFICATION NUMBER _____ GROUP NAME/NUMBER _____

NAME OF SECONDARY INSURANCE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

IDENTIFICATION NUMBER _____ GROUP NAME/NUMBER _____

ASSIGNMENT OF BENEFITS – AUTHORIZATION AND ACKNOWLEDGEMENT

I hereby assign all medical and surgical major medical insurance benefits to which I am entitled. I hereby authorize and direct my insuranc carrier(s), including Medicare, private insurance and any other health/medical plans, to issue payment checks directly to Dr. Jay S. Stauffer fo medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

I hereby authorize care by Dr. Jay S. Stauffer.

_____ _____
Signature of Patient/Parent/Guardian Date

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NAME:_____ DATE OF BIRTH:_____

PERSONAL MEDICAL HISTORY

1. Reason for today's visit?_____

2. Are you being treated for any of the following? Please circle yes or no.

High Cholesterol	Yes	No	Cancer (type)_____		
Abnormal Heart Rhythm	Yes	No	Vascular Disease	Yes	No
Congestive Heart Failure	Yes	No	Kidney Disease	Yes	No
Heart Disease	Yes	No	High Blood Pressure	Yes	No
Diabetes	Yes	No	Pacemaker	Yes	No
Stroke	Yes	No	Defibrillator	Yes	No
Gallbladder Disease	Yes	No	Liver Disease	Yes	No
Cirrhosis	Yes	No	Hepatitis Type_____	Yes	No
COPD	Yes	No	Emphysema	Yes	No
Bleeding Problems	Yes	No	Thyroid Disease	Yes	No

Other Conditions_____

3. Current height_____ Current weight_____

4. Have you ever had a colonoscopy? Yes No If so, when?_____

5. Have you had a mammogram or ultrasound of the breast in the last 27 months?_____

6. Have you had an influenza vaccination? Yes No If so, when?_____
Have you had a pneumonia vaccination? Yes No If so, when?_____

7. Have you ever had problems with either local or general anesthesia? Yes No
If so, what type of problem?_____

8. Are you pregnant?_____When was your last menstral period?_____Number of children?_____Ages?_____

OPERATIONS – List all operations. Give the year, physician and location.

MEDICATIONS – List all medications (prescription and nonprescription), the dose and frequency.

ALLERGIES – List any allergies to medications and the allergic reaction caused.

SOCIAL HISTORY

1. Tobacco use? Yes No If so, how much, what type and for how long?_____
Previous Tobacco Use? Yes No If so, how much, what type and for how long?_____

2. Alcohol use? Yes No If so, how much, what type and for how long?_____

3. Illegal drug use? Yes No If so, how much, what type and for how long?_____

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NAME:_____ DATE OF BIRTH:_____

FAMILY HISTORY					
Please indicate if any of your immediate family has had any of the following medical problems.					
	Family Member(s)				Family Member(s)
Heart disease	Yes	No	High blood pressure	Yes	No
Stroke	Yes	No	Kidney disease	Yes	No
Diabetes	Yes	No	Cancer	Yes	No
Bleeding problems	Yes	No	Type of cancer		
			Family member		
Other Medical Problems					

REVIEW OF SYSTEMS – Do you experience any of the following, please check all that apply.

GENERAL
☐ Weight loss ☐ Weight gain ☐ Exhaustion/fatigue ☐ Fever ☐ Chills
☐ Discomfort/fullness/malaise

SKIN
☐ Rashes ☐ Lesions ☐ Lumps/masses ☐ Cancer ☐ Wounds ☐ Discoloration
☐ Changes in moles

LYMPHATIC
☐ Swollen nodes in neck, groin, arm pit ☐ Painful nodes in neck, groin, arm pit

HEAD
☐ Headache ☐ Blurred Vision ☐ Double vision/diplopia ☐ Dizziness

EARS
☐ Ringing/tinnitus ☐ Hearing Loss ☐ Pain ☐ Tenderness ☐ Dizziness

EYES
☐ Blurred Vision ☐ Diplopia ☐ Painful Vision ☐ Drainage

NOSE
☐ Drianage/rhinitis ☐ Bleeding ☐ Skin lesion

THROAT
☐ Soreness/pharyngitis ☐ Hoarseness ☐ Redness ☐ Drainage

ENDOCRINE
☐ Heat intolerance ☐ Cold intolerance ☐ Nervousness ☐ Abnormal swelling

BREAST
☐ Discharge ☐ Tenderness/pain ☐ Nodules/lumps/masses

PULMONARY
☐ Shortness of breath ☐ Coughing blood/hemoptysis ☐ Wheezing ☐ Coughing up phlegm

CARDIOVASCULAR
☐ Chest pain ☐ Chest pain with exertion ☐ Pounding heart/palpitations ☐ Heart murmur

GASTROINTESTINAL
☐ Diarrhea ☐ Constipation ☐ Blood in stool/hematochezia ☐ Hemorrhoids ☐ Cramping
☐ Heart burn ☐ Abdominal pain ☐ Nausea ☐ Vomiting ☐ Vomiting blood/hematemesis
☐ Painful swallowing ☐ Fullness ☐ Regurgitation

GENITOURINARY
☐ Painful & difficult urination/dysuria ☐ Blood in urine/hematuria ☐ Unable to urinate/dysuria
☐ Discharge ☐ Frequent urination ☐ Decreased stream ☐ Hesitancy ☐ Incomplete voiding

MUSCULOSKELETAL
☐ Joint pain ☐ Back pain ☐ Muscle pain ☐ Decreased movement ☐ Swollen joints
☐ Bony deformity ☐ Inability to move ☐ Masses

NEUROLOGIC
☐ Headaches ☐ Numbness ☐ Weakness ☐ Seizures ☐ Memory loss ☐ Tingling
☐ Confusion

PSYCHIATRIC
☐ Hallucinations ☐ Unexplained voices ☐ Depression

I hereby state that the completed medical history form is true and correct to the best of my knowledge.

Patient Signature_____ Date_____

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FINANCIAL RESPONSIBILTY

I understand that all professional services rendered are charged to the patient or guarantor and are due and payable at the time of service, unles other arrangements have been made in advance. Necessary forms will be completed to file for insurance carrier benefits. I have requested service from Dr. Jay S. Stauffer on behalf of myself and/or my dependents, and understand that be making this request, I become fully financially responsibl for any and all charges incurred in the course of the treatment authorized.

I understand that there will be a $30.00 service fee on all returned checks.

I understand that there must be 24 hours advance notice to cancel a scheduled appointment. Missed appointments may be subject to a $20.00 servic charge.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Jay S. Stauffer to: (1) release any information necessary to insurance carriers regarding my illness or treatments; (2) proces insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to process insurance claims for th period of a lifetime. This order will remain in effect until revoked by me in writing.

A photocopy of this assignment is to be considered as valid as the original.

PATIENT HIPAA CONSENT FORM

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contain a Patients Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The practic reserves the right to change the Notice of Privacy Practices as needed.
By signing this form, you consent to our use and disclosure of protected health information for purposes of treatment, payment and healthcar operations. You have the right to revoke this consent in writing and signed by you. Such a revocation will not affect any disclosures we have alread made in reliance on you prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act 1996 (HIPAA).

Dr. Jay S. Stauffer and/or staff may contact me in the following manner (check all that apply):

Home Telephone
☐ Ok to leave detailed message on machine
☐ Ok to leave message with call back number only
☐ Ok to leave message with family member

Cellular Phone
☐ Ok to leave detailed message on voicemail
☐ Ok to leave message with call back number only

Work Telephone
☐ Ok to leave detailed message on machine
☐ Ok to leave message with call back number only
☐ Ok to leave message with co-worker

Written Communication
☐ Ok to mail to my home address
☐ Ok to mail to my work/office address
☐ Ok to fax to this number_____

E-Mail
☐ E-Mail Address_____
☐ Permission to E-Mail to above address

I authorize Dr. Jay S. Stauffer and/or staff to release information pertaining to my condition and/or care to all other treating physicians involved i my care.

Please list any other individuals or family members that we may release information to:

_____
Print Name Phone Number

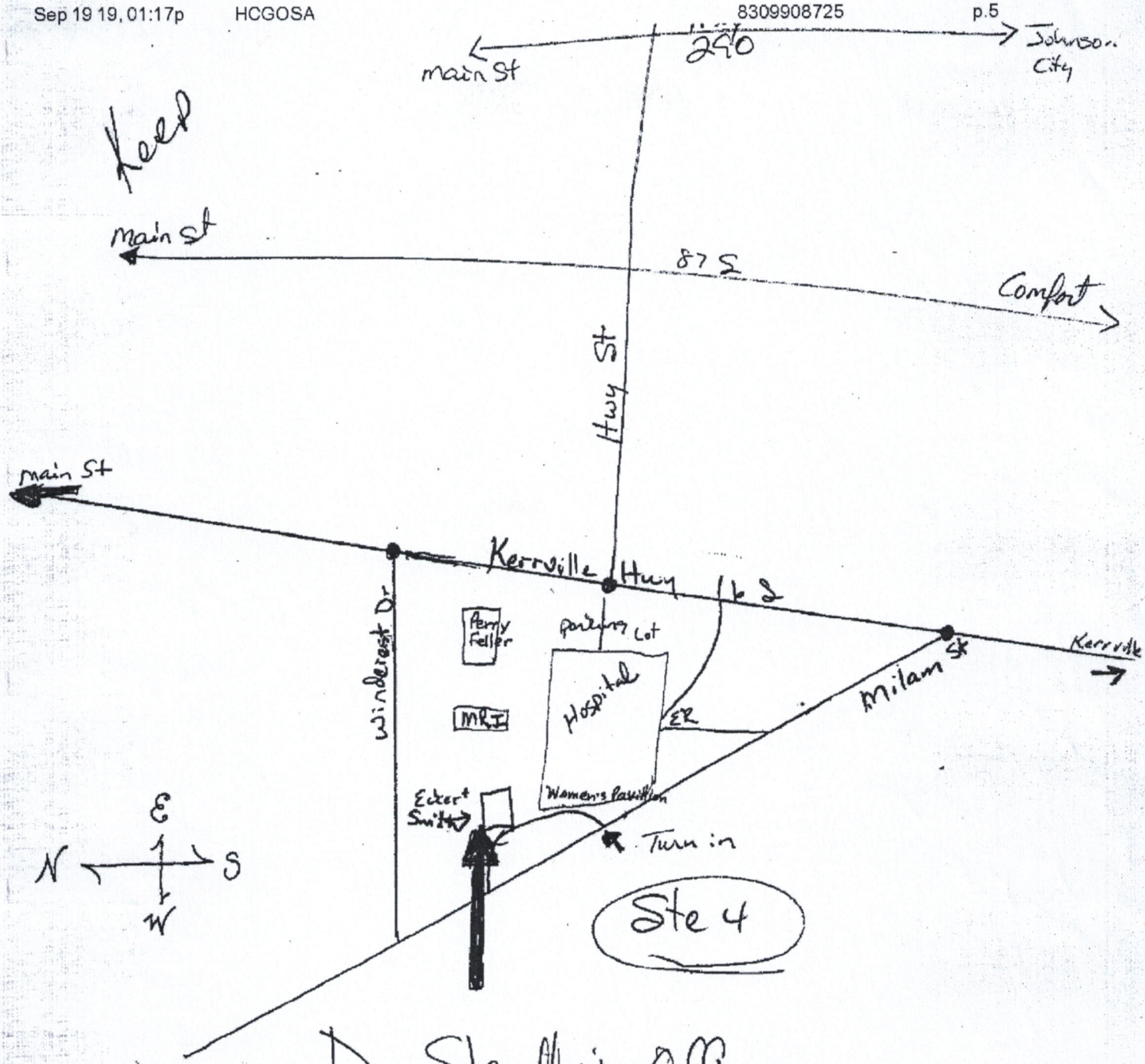
_____
Print Name Phone Number

_____
Print Name Phone Number

I have read and understand all the above policies.

_____
Signature of Patient or Guardian Date

NOTE: AUTHORIZATIONS IN EFFECT FOR TWELVE MONTHS



Dr Stauffer's Office

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