FILL IN ALL PATIENT INFORMATION

First Name _____ Middle _____

Last Name _____

Social Security # _____

Sex _____ Date of Birth _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

(Check One) ☐ Employed ☐ Retired ☐ Full Time Student ☐ Other _____

Employer _____

Mailing Address _____

City, State Zip _____

Email _____

Contact Phone _____

Cell/Work Phone _____

Primary Care Doctor: _____

Referring Physician _____

PLEASE PROVIDE FRONT DESK WITH ALL INSURANCE INFORMATION

GUARANTOR / RESPONSIBLE PARTY IF NOT PATIENT FOR INSURANCE AND/OR EMERGENCY CONTACT INFORMATION

Social Security # _____

Relationship _____

First Name _____ Middle _____

Last Name _____

Address _____

City, State Zip _____

Sex _____

Daytime Phone _____

Employer _____

Address _____

City, State Zip _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims

I HEREBY AUTHORIZE ANY MEDICAL RECORDS NEEDED TO THE CONTNUATION OF MY CARE BE RELEASED TO ANGELINA SURGICAL ASSOCIATES.

_____

Signature (Patient or Parent if Minor) Date

FOR OFFICE USE ONLY

OFFICE NOTES____OPERATIVE REPORTS____RADIOLOGY____LAB/PATHOLOGY____
DEMOGRAPHIC/INSURANCE INFORMATION____OTHER_____

____DR. DARRY MEYER
____DR. ALAN BASSIN
____DR. JEFFREY HAMAKER
____DR. ASHLEY MCELROY

PHONE 936-634-8216
FAX 936-634-8723

Angelina Surgical Associates

Office use only: ☐Wheelchair ☐Stretcher

Patient Questionnaire

Date:_____

Patient's Name: _____ DOB: _____

Best Contact Number: _____ Emergency Contact: _____ Cell:_____

YOU MUST fill out this page- OMITING INFO COULD CAUSE SERIOUS PROBLEMS DURING YOUR SURGERY*

***Do you currently have: ☐Rashes ☐Fever ☐ Other:_____

If you have any paperwork (tests, labs, prescription list, etc please give to front desk)

Reason for Visit: _____

Allergies: _____ Allergic Reaction to Anesthesia: YES NO

Family Doctor: _____

Opthamologist (Eye): _____ Month/ Year

Pulmonologist (Lung): _____ Month/ Year

Cardiologist (Heart): _____ **Last Seen:** ____/____ Month/ Year

Height: ____' ____" **Weight:** _____ Lbs **Pharmacy:** _____ **Pharmacy Street:** _____

Do you take any of the following below in PILL form, Please check:

Pills or Tablets: ☐Aspirin ☐BC Powder ☐Alka-Seltzer ☐Advil ☐Aleve ☐Ibuprofen ☐Motrin ☐Cayenne ☐Cinnamon ☐CoQ10 ☐Garlic ☐Fish Oil ☐Naproxen ☐Omega-3 ☐Saw Palmetto ☐Turmeric ☐Vitamin E ☐Multivitamins ☐Ginger

Prescription Medications

Prescription Medications:	Dosage:# of times taken daily:	Mg/Mcg/Units:	Prescription Medications:	Dosage:# of times taken daily:	Mg/Mcg/Units:

☐ Eliquis(Apixaban:_____ ☐ Coumadin(Warfarin):_____ ☐ Diclofenac:_____ ☐ Pletal (Cilostazol):_____

☐ Pradaxa(Dabigatran): _____ ☐ Plavix (Clopidogrel): _____ ☐ Mobic (Meloxicam):_____ ☐ Blood thinners not mentioned here: _____

☐ Xarelto(Rivaroxaban):_____ ☐ Brilinta(Ticagrelor): _____ ☐ Diet Pills:_____

SCREENINGS:

If you are aged **21 - 64 years**, have you had a Mammogram? ☐ _____ Approximate Year Pap Smear ☐ _____ Approximate Year

If you are aged **40 - 75 years**, Have you had a Colon Cancer Screening? If YES, When?_____ Approximate Year

Are you using tobacco products? ☐Yes ☐No If yes, check : ☐ Smoke ☐ Chew ☐ Vape, How Long:_____ If No, Have you in the past? YES NO

Must check

Have you had a Blood Transfusion?: YES or NO If YES, did you have a reaction? YES or NO

Parent: (Please mark at least one)

Dad Alive: ☐ Age :_____ Dad Passed: ☐ Age: _____ **Does Parent have:** ☐Diabetes ☐Heart Disease ☐Cancer

Mom Alive: ☐ Age :_____ Mom Passed : ☐ Age : _____ **Does Parent have:** ☐Diabetes ☐Heart Disease ☐Cancer

Are you? ☐ Married ☐ Divorced ☐ Single ☐ Widowed **Do you live Alone?** ☐Yes ☐ No

Are you Working? ☐Yes ☐ No If Yes, Where? _____

***WOMEN ONLY**:

Are you Pregnant? YES or NO Date of Last Menstrual Cycle: _____

Number of Pregnancies: _____ Number of Children: _____

Angelina Surgical Associates

Darry G. Meyer D.O. **Alan Bassin M.D.** **Jeffrey Hamaker M.D.** **Ashley McElroy M.D.**

302 Medical Park Drive, Suite 101
Lufkin, Texas 75904
Phone 936-634-8216 Fax 936-634-8723

Office Policy

Our office is pleased to accept your insurance assignment on your surgery as soon as your exact coverage is verified. We will file your claim forms and assist you in every way we can. However, you are responsible for full payment according to your insurance policy, on your initial visit and for any surgery or procedures on or before the day services are rendered. Follow up visits for the first two weeks after surgery are non-chargeable.

Office policy regarding insurance assignment:

1. You must understand that the contract you have is between you and your insurance company and **you are fully responsible for any amount not paid by your insurance company.**
2. Once your insurance remits payment, any balance will be due in full at that time. Arrangements must be made in advance for our office to agree to any other payment arrangements.
3. Our office does not guarantee that your insurance will pay. We will make every attempt at the beginning of your health care to receive verification of your policy and what it covers. However, if for some reason your claim is denied, **you are responsible for the full amount of your bill.**
4. You are required to sign a statement authorizing the payment to be directly to our office.
5. Our office will **not** enter into a dispute with your insurance company over the claim. This is your responsibility and obligation.
6. Delinquent accounts will be turned over to a collection agency when deemed necessary.
7. If for some reason you are unable to keep a scheduled appointment, we request that you notify us 24 hours in advance.
8. If you **No-Show** for 3 appointments, the doctor reserves the right to terminate the physician/patient relationship.
9. If you do not show up for a scheduled appointment and you do not call to cancel the appointment prior to your scheduled time, you will be charged a **$35.00 NO SHOW FEE.**

By signing this statement, you are stating that you understand and agree to follow this policy.

_____ _____

Signature Date

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can 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 received, read (or had the opportunity to read if I chose) and understood the preceding Notice of Privacy Practices of Angelina Surgical Associates containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices, but was unable to do so as documented below;

Date	Initials	Reason

_____
Patient Signature (or Authorized Representative)

_____
Printed Name

_____
Relationship to Patient

_____
Date

Listed below are the person(s) that have my permission to receive medical information regarding my health.

Print Contact Name	Relationship
Print Contact Name	Relationship
Print Contact Name	Relationship