General Surgeons of Pasadena

Patient Information

Date:	Home Phone: ( )	Cell: ( )
Last Name:	First Name:	Middle:
Social Security #:	Driver's License #:	Date of Birth:
Street Address:	E-Mail Address:	
City:	State:	Zip Code:
Sex: ☐Male ☐Female Transgender☐	Marital Status: Married☐Widowed☐Single☐Minor☐Separated☐Divorced☐ Partnered for _____ Years	

Race: American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined ☐

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined

Language: ■English ☐Spanish ☐Indian ☐Japanese ☐Chinese ☐Korean ☐French ☐German ☐Russian ☐Other

Employer Name/School Name:

Employer/School Address:

Occupation:	Business Phone:

Responsible Party Information (if different from above)

Last Name:	First Name:	Middle:
Social Security #:	Driver's License #:	Date of Birth:
Street Address:	E-Mail Address:	
City:	State:	Zip Code:

Employer Name/School Name:

Employer/School Address:

Occupation:	Business Phone:

Relationship to patient:

Primary Insurance Information

(provide your insurance card to the front desk at check-in)

Name of Insured:	Patient Relationship to Insured	
Insurance Company/Phone Number:		
Insurance Company Claim Address:		
Subsciber ID:	Group ID:	Copay Amount:
Effective Date:	Termination Date:	____ Female ____ Male
Insured Date of Birth:	Insured's Social Security Number:	

Secondary Insurance Information

(provide your insurance card to the front desk at check-in)

Name of Insured:	Patient Relationship to Insured	
Insurance Company/Phone Number:		
Insurance Company Claim Address:		
Subsciber ID:	Group ID:	Copay Amount:
Effective Date:	Termination Date:	____ Female ____ Male
Insured Date of Birth:	Insured's Social Security Number:	

Authorization, Consent, and Assignment of Benefits

I certify that I have insurance with the above listed insurance company and assign directly to General Surgeons of Pasadena all insurance benefits, in any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid or not paid by insurance. I authorize the use of my signature on all insurance submission. General Surgeons of Pasadena may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Patient Signature or Guardian/Personal Representative — Date

_____ _____

Patient Signature or Guardian/Personal Representative — Date

Revised June 2011

Health History

Confidential

Patient Name:		Today's Date:
Age:	Birthdate:	Date of Last Physical Exam:
What is your reason for today's visit?:		

Symptoms

Check (√) conditions you currently have or have had in the past year.

General

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of Weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

Muscle/Joint/Bone

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

Genito-Urinary

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Gastrointestinal

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Cardiovascular

- ☐ Chest Pain
- ☐ High Blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

Eye, Ear, Nose, Throat

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed Eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear Discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

Skin

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last Menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Conditions

Check (√) conditions you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

Medications — List medications you are currently taking		Allergies
Pharmacy Name: Phone:		

Family History

Confidential

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (√) if, your blood relatives had any of the following: Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Strokes	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates _____

Serious Illness/Injuries	Date	Outcome

Pregnancies'

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (√) which you use and how much you use:

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

Occupational

Check (√) if your work exposes you to:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation:

To the best of my knowledge, the above information is complete and correct. I understand that if is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please Print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

Reviewed By — Date

HCA Physician Services
General Surgeons of Pasadena
3801 Vista Road, Ste 450
Pasadena, TX 77504

Phone Message Consent

I give permission for **General Surgeons of Pasadena** to call me or leave me a message for the purpose of notification of results or reminders of appointments at the following number(s):

_____Home Phone Number_____
(PT Initials)

_____Work Phone Number _____
(PT Initials)

_____Cell Phone Number_____
(PT Initials)

_____ Emergency Contacts Number_____
(PT Initials)

Please read below and consider carefully who you want to have access to your medical information. Unless we have your written permission to do so, **we will not.**

I give permission for **General Surgeons of Pasadena** to discuss anything regarding my medical care with the following person (s):

NAME: _____**RELATIONSHIP:**_____

NAME: _____**RELATIONSHIP:**_____

NAME: _____**RELATIONSHIP:**_____

_____ _____ _____
Patient Name (Print) **Patient Signature** **Date**

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	Employee Job Title
Signature of Witness	**Date**

HCA Physician Services
General Surgeons of Pasadena
3801 Vista Road, Ste 450
Pasadena, TX 77504

Assignment of Benefits

I hereby assign to General Surgeons of Pasadena any insurance other third-party benefits available for health care services provided to me. I understand that General Surgeons of Pasadena has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to General Surgeons of Pasadena, I agree to forward to General Surgeons of Pasadena all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

Signature of Patient/Legal
Guardian: _____

Date _____

HCA Physician Services
General Surgeons of Pasadena
3801 Vista Road, Ste 450
Pasadena, TX 77504

Thank you for choosing General Surgeons of Pasadena. Our provider and staff are dedicated to providing excellent quality healthcare to each of our patients.

General Surgeons of Pasadena would like to invite you to participate in our Patient Satisfaction Survey. Our survey will be sent to you, via email, after your visit. Our survey will help us to ensure each of your visits is a pleasant experience and also let us know how we can improve to serve you. Your time spent filling out our survey is greatly appreciated.

_____
Patient Email Address

_____
Patient Name

David N. Lam, M.D.