Prairie Surgical Care Carlo Jurani, M.D. Benjamin Stone, M.D. Phone 913-432-4355 Fax 913-432-5994

PATIENT HISTORY – SELF REPORTING

Welcome to our office. Thank you for arriving early to complete this form.

			Date:
Name *(Last, First, M.I.):*		☐ M ☐ F	DOB:
Previous or referring doctor:		Phone number of your doctor:	

PERSONAL HEALTH HISTORY

Describe reason for visit.

When did it start?

Where does it hurt?

Rate severity: (1 mild, 10 severe)

What makes it better / worse?

Previous episodes?

Medical History:	**☐ None** ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Respiratory Disease			
Events and Dates:	☐ Blood Clot		☐ Pneumonia	
	☐ Hepatitis		☐ Heart Attack	
	☐ Cancer		☐ Stroke	

List any other medical problems that other doctors have diagnosed.

Operations **☐ None**

Year	Reason	Hospital
	Ever had colonoscopy? ☐ yes ☐ no	

Recent hospitalizations **☐ None**

Year	Reason	Hospital
	Ever had a blood transfusion? ☐ yes ☐ no	

List your prescribed drugs and over-the-counter drugs. We will photocopy your list if available. **☐ None**

Name the Drug	Strength	Frequency Taken
Are you taking any blood thinners? ☐ yes ☐ no	Aspirin Plavix	Coumadin Warfarin

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ALLERGIES ☐ **None** ☐ **Latex**		
Name the Drug	Reaction You Had	Date

SOCIAL HISTORY

Alcohol	Do you drink? ☐ Yes ☐ No What kind / amount?	**Tobacco**	Cigarettes ☐ Yes ☐ No _________ pk/day number of years ____________ Year quit ___________
Work	Type	**Drugs**	Recreational or street drugs? ☐ Yes ☐ No List:

FAMILY HEALTH HISTORY

Examples: Breast cancer, heart disease, blood clots, diabetes, bleeding disorders, colon cancer, ovarian cancer

Relationship	AGE	SIGNIFICANT HEALTH PROBLEM	Relationship	AGE	SIGNIFICANT HEALTH PROBLEM

MENTAL HEALTH			PERSONAL SAFETY		
Is stress a major problem for you?	☐ Yes	☐ No	Do you live alone?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No	Do you have frequent falls?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No	Do you have vision or hearing loss?	☐ Yes	☐ No
Do you have problems eating or your appetite?	☐ Yes	☐ No	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No

WOMEN ONLY	MEN ONLY		
Date of last menstruation:	Do you get up to urinate at night? # of times _____	☐ Yes	☐ No
Any problems with control of urination? ☐ Yes ☐ No	Any testicle pain or swelling?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____	Problems emptying your bladder completely?	☐ Yes	☐ No

REVIEW OF SYSTEMS

Check the positives in boxes that applies to you

__**Constitutional**	☐ weight changes	☐ fever	☐ fatigue	☐ sweats		
__**Skin**	☐ rashes	☐ itches	☐ changing moles	☐ lumps	☐ skin cancer	
__**Eyes/Head**	☐ headache	☐ vision changes	☐ double vision	☐ dizziness	☐ pain	
__**ENT**	☐ hearing changes	☐ vertigo	☐ sinusitis	☐ nose bleed	☐ sore throat	
__**Respiratory**	☐ shortness of breath		☐ cough	☐ chest wall pain	☐ sputum	
	☐ wheezing	☐ asthma	☐ coughing up blood	☐ snoring	☐ history of TB	
__**Cardiovascular**	☐ chest pain	☐ shortness of breath on exertion		☐ extremity swelling	☐ heart murmur	
	☐ palpitations	☐ leg cramps	☐ blood clots	☐ high blood pressure		
__**Gastrointesinal**	☐ poor appetite	☐ painful swallowing	☐ heartburn	☐ nausea/vomiting	☐ jaundice	
	☐ abdominal pain	☐ blood or tarry looking stools		☐ diarrhea	☐ constipation	☐ hemorrhoids
__**Genitourinary**	☐ pain on urination	☐ bloody urine	☐ frequent urination	☐ urgency	☐ hesitancy	
	☐ incontinence	☐ vaginal or urethral discharge		☐ testicular pain or swelling		
__**Musculo-skeletal**	☐ joint or back pain	☐ swelling	☐ stiffness	☐ deformity	☐ muscle aches	☐ weakness
__**Neurological**	☐ dizziness	☐ passing out	☐ strokes	☐ muscle weakness or paralysis		
	☐ memory changes	☐ speech disturbances		☐ seizures		
__**Psychiatric**	☐ depression	☐ sleep disturbance	☐ suicidal ideation	☐ anxiety	☐ eating disorder	☐ hallucinations
	☐ delusions	☐ behavioral changes				
__**Hematologic**	☐ anemia	☐ easy bruising	☐ heavy bleeding			
__**Endocrine**	☐ heat intolerances	☐cold intolerance	☐ frequent urination	☐ excessive thirst		
__**Immunologic**	☐ seasonal allergy	☐ lupus	☐ rheumatoid arthritis			
__**Functional Status**	difficulties with…	☐ bathing	☐ ambulating	☐ dressing	☐ cooking	

☐ All other review of systems negative

Physician Initial ____________

PATIENT FULL NAME:____ **Sex: male female**

Social Security Number:________**-**________**-**________ **Date of Birth:**________________ **Age:**________

Street Address:____ **PO Box:**__________

City / State:____ **Zip Code:** __________

Home Phone:________________ **Cell Phone:**________________ **Work Phone:**________________

Preferred Method of Contact: ☐ **Home** ☐ **Cell** ☐ **Work** **Email address:**________________________

Special Contact Instructions:____

Patient Status: Married Single Divorced Widowed Employed Retired Student: FT PT

Spouse's Name:________________________________ **Phone:**________________

Emergency notification: ________________________________ **Phone:**________________

Patient's Employer:____

Employer Address :____

Current Medical Condition: Work Related ______ **Auto Accident**______ **(state**______**) Workers Comp**__________

Date of Occurrence:________________

REFERRING PHYSICIAN:________________________________ **Phone:**____________

PRIMARY CARE PHYSICIAN:________________________________ **Phone:**____________

OTHER SPECIALTY PROVIDERS:____

PHARMACY NAME & PHONE:____

Has Dr. Jurani ever treated someone you know? ________________________________

INSURANCE INFORMATION

PRIMARY INSURANCE:________________________________ **HMO/PPO Copay:$**______ **%**______

Subscriber Name:________________________________ **DOB:**________________

Subscriber's Employer:________________________________ **Effective Date:**____________

SECONDARY INSURANCE:____ **HMO / PPO**

Subscriber Name:________________________________ **DOB:**________________

Subscriber's Employer:________________________________ **Effective Date:**____________

Patient Signature:________________________________ **Date:**________________

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PATIENT FINANCIAL POLICY

Thank you for choosing Prairie Surgical Care. If you have any questions regarding our fees or patient responsibilities, please feel free to discuss them with any of our staff. We encourage our patients to contact their insurance company to verify Prairie Surgical Care is a participating provider and to familiarize themselves with their insurance plan benefits, prior to their appointment. *If you are unable to keep your appointment please let us know so we may offer your time to another patient in need.* When you first check in, we will ask for your insurance card(s) and a photo ID. These cards will be copied and scanned into our system. Please inform us of any changes in your information: insurance, mailing address, phone numbers, pharmacy information etc.

REFERRALS: Some insurance plans require a referral from your Primary Care Physician. It is the patient's responsibility to obtain any and all referrals prior to your appointment. We will reschedule any appointment if the referral is not secured.

COPAYMENTS: Please be prepared to pay your co-pay at the time of service. We will reschedule appointments if you are unable to pay the co-pay, unless prior arrangements have been made. There is no co-pay for most post operative visits.

DEDUCTABLES: When an office visit copayment is not designated on your insurance card, an estimate of patient responsibility will be obtained from your insurance company when possible. Patients will be responsible to pay that estimated cost at the time of service.

PATIENT BALANCES: Coinsurance and deductable balances for office visits and procedures are due upon receipt of your statement. If your responsibility is more than you are able to pay, we are willing to set up a convenient 6 month payment plan. We will be happy to answer any questions you may have regarding these balances. Contact us at 913-432-4355

SELF PAY: Patients without insurance will be considered self pay. The new patient fee is $100.00 and established patients fee is $50.00. This fee is required at time of service. There will be an additional fee if an in-office procedure is performed.

FEES: FMLA/DISABILITY FORMS: Our fee is $15.00. Forms are completed after your post-operative visit to ensure accurate return to work dates. This eliminates incurring additional fees when forms are corrected or filled out multiple times. We are happy to provide a Work Release free of charge. There is a $25.00 charge for any returned checks for insufficient funds.

WE ACCEPT: Checks, Cash, Credit Cards, Debit Cards and money orders (Visa, MC & Discover)

RESPONSIBLE PARTY SIGNATURE:____________________________________ DATE___________

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PATIENTNAME:____ DOB:_________________________

****

I hereby give permission for the physician and office staff of PRAIRIE SURGICAL CARE to discuss my **MEDICAL CONDITION AND CARE** with the following persons (i.e. family members, friends, employers, etc.):

Name	Relationship	Phone

****

I hereby give my permission for the office staff at PRAIRIE SURGICAL CARE to discuss my **ACCOUNT INFORMATION** with the following person:

Name	Relationship	Phone

****

I understand that if I want to request **COPIES OF MY MEDICAL RECORDS**, that my request will need to be made either in person or in writing, including my signature.

SIGNED:____ DATE:____________________

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Form of Written Acknowledgement of Receipt of
Prairie Surgical Care's Notice of Patient Privacy Practices

By signing below, I acknowledge receipt of Prairie Surgical Care's Notice of Patient Privacy Practices.

Signature of Patient or Legal Representative:__________________________ Date:___________
Printed Name of Patient: ____

Form of Written Acknowledgement and Understanding of
Patients Consent to-treat and Assignment of Benefits

While I am here I permit the employees, Dr Jurani, Dr Stone, and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand Dr Jurani and Dr Stone will explain to me the nature of my condition and his recommended treatment and any associated risk involved. I also understand that he will explain to me other ways this condition could be treated. I further understand that this care may include tests, examinations, medical and/or surgical treatment, No guarantees have been made to me about the outcome of this care.

I hereby authorize Prairie Surgical Care to release all information necessary to secure payment. I assign all benefits for unpaid service to which I am entitled to Prairie Surgical Care. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I request that payment of authorized commercial insurance, Medicare and Medigap benefits be made on my behalf to Prairie Surgical Care. I authorize any holder of medical information about me to release to Medicare (HCFA) and its agents and/or Medigap any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient or Legal Representative:____________________________ Date:___________

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