Patient Registration Form

Patient Name: _____ Social Security # _____

Date of Birth: ____/____/____ Sex: M / F Marital Status: Single / Married / Divorced / Widowed

Address: _____
(Street) (City/State/Zip)

Home phone: _____ Mobile: _____ Work: _____

Email Address: _____ Would you like to be set up on our Patient Portal? Y / N

Employment: ___Full Time ___Part time ___Self ___Retired ___Student ___Unemployed

Employer: _____

Who to call for an emergency:

Name: _____ Address: _____

Phone Number: _____ Relationship: _____

FIRST INSURANCE INFORMATION: (please present your insurance card for our staff to copy)

Plan Name: _____ Address: _____

I.D. Number _____ Group Number: _____

Policy Holder: _____ DOB: ____/____/____ SS #: _____

SECOND INSURANCE INFORMATION: (please present your insurance card for our staff to copy)

Plan Name: _____ Address: _____

I.D. Number _____ Group Number: _____

Policy Holder: _____ DOB: ____/____/____ SS #: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

The Providers at Surgical Associates of Myrtle Beach use an electronic medical record system that allows electronic prescribing of medications. Medications are sent to your pharmacy through a secure electronic prescription connection (Rx Hub) which improves the timely and accurate transmission of your medication information. To optimize the use of this electronic capability, and coordinate your care between us and other specialists, we ask that patients to allow us to access their medication history through the Rx Hub.

Please check only ONE of the following:

☐ I consent to allow my provider to access ALL of my medication history.

☐ I DO NOT consent to my provider accessing any of my medication history.

Referring Physician: _____ Primary Care Doctor: _____

Reason For Visit: _____

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1. I authorize the release of any medical information necessary to process claims to my insurance company and medical providers/facility, and request payment to Surgical Assoc. of MB. I acknowledge that I am financially responsible for payment whether covered by insurance or not. _____
2. I authorize the receipt of my medical records to Surgical Assoc. of MB from other medical providers/facilities. _____
3. I have read and understand the financial policy of Surgical Assoc. of MB and wish to have services provided to me. _____
4. I understand that if I NO SHOW to ANY appointment that there will be a $50.00 charge to my account. _____

(Please initial each line above)

Signature of patient/Responsible party (if minor) _____ Date _____

Medical History Form

Patient Name: _____ DOB: _____/_____/_____

Personal History:

Height: _____ Weight: _____

Tobacco History? Current Smoker Former Smoker Never Smoker How much per day? _____

Alcohol History? Current Drinker Former Drinker Never Drinker How much per day? _____

Do you drink coffee, tea, soda? Yes No How much per day? _____

Current Medications & Dosages/ **If none, check here** ☐

Medication	Dosage	Frequency
(you may attach a list)		

Allergies to Medications/ **If none, check here** ☐ _____

_____

Previous Surgeries/ **If none, check here** ☐ _____

_____

Please **check** Yes or No for all that apply:

Eye Problems	**Y**	**N**	**Neurological**	**Y**	**N**
Glasses			Seizures		
Contacts			Stroke		
Cataracts			TIA		
Glaucoma			Frequent Severe Headaches		
Recent Vision Changes			Neuropathy		
Ear Problems	**Y**	**N**	**Skin Disorders**	**Y**	**N**
Hard of Hearing			Open Wounds		
Hearing Aid			Rash		
Ringing in Ears			Cellulitis		
Ear Pain			Abscess		
Neck Problems	**Y**	**N**	Other:		
Neck Pain			**Psyche**	**Y**	**N**
Lumps or swelling of the neck			Depression		
Other:			Anxiety		

Medical History Form Continued

Patient Name: _____ DOB: _____/_____/_____

Respiratory	**Y**	**N**	**Gastrointestinal**	**Y**	**N**
Asthma			Hiatal Hernia		
Bronchitis			Gallbladder Disease		
COPD			Gastric Ulcers		
Emphysema			Crohn's Disease		
Cardiac	**Y**	**N**	Irritable Bowel Syndrome		
Heart Attack			Reflux		
Heart Disease			Weight Gain		
Irregular Heartbeat			Weight Loss		
Hypertension			Blood in Stool		
Congestive Heart Failure			Diverticular Disease		
Defibrillator			**Genitourinary**	**Y**	**N**
Pacemaker			Kidney Disease		
Atrial Fibrillation (AFIB)			Kidney Stones		
Swelling of Ankles and/or Feet			Kidney Infection		
Heart Murmur			Prostate Problems		
Valve Replacement			**Blood, Lymph, Liver Disease**	**Y**	**N**
High Cholesterol			Hepatitis A		
Peripheral Vascular	**Y**	**N**	Hepatitis B		
Leg Pain When Walking			Hepatitis C		
Cold and/or Numb Feet			HIV		
Change in Foot Color			Cirrhosis		
Varicose Veins			Clotting Disorder		
Aneurysm			Jaundice		
Carotid Bruits			Lymphedema		
Cancer	**Y**	**N**	**Endocrine**	**Y**	**N**
Colon/Rectal			Diabetes Type 1		
Breast			Diabetes Type 2		
Ovarian			Thyroid Disease		
Prostate			Lupus		
Other:			**Musculoskeletal**	**Y**	**N**
Other	**Y**	**N**	Back Problems		
Pregnant (if applicable)			Rheumatoid Arthritis		
Have you received your Flu Shot?			Osteoarthritis		
If so when? (mo/year)			Fibromyalgia		
If No, are you planning to receive it?			Joint Replacement		

Medical History Form Continued

Patient Name: _____ DOB: _____/_____/_____

Family History:

If any **blood** relative has suffered any of the following, please notate:

CONDITION	RELATIONSHIP TO YOU	ALIVE/DECEASED
Alcoholism		
Bleeds easily		
Colon cancer		
Ovarian cancer		
Breast cancer		
Diabetes		
Hypertension		
Heart Disease		
Stroke		
PVD		
Diverticular Disease		
Other _____		

Signature of patient/Responsible party (if minor) _____ Date _____

Surgical Associates of Myrtle Beach

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Lane I. Moore, M.D., F.A.C.S.

845 82nd Parkway

Myrtle Beach, SC 29572

Phone (843) 449-9621

Fax (843) 449-4921

Date: _____

Patient: _____ DOB: _____

I authorize my medical records and any medical information necessary to be released and obtained by Surgical Assoc. of MB to assist in the improvement of my quality of health. I have read and understand the medical release policy of Surgical Assoc. of MB and agree to the above.

_____ _____

Patient's Signature Date

_____ _____

Witness Signature (employee only) Date