

Surgical Associates of Myrtle Beach Established Patient History Update Form

Today's Date: _____

Patient Name: _____ DOB: _____

Marital Status: Single Married Widowed Divorced Separated

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____

Email Address: _____ Would you like to be set up on our patient portal? Yes No

Employment: Full Time Part Time Self Retired Student Unemployed

Employer: _____

Has your Insurance changed since your last visit? Yes No

If yes, please fill in chart below:

Primary Ins. Name:	Subscriber Name/DOB:	ID #:	Group #:
Secondary Ins. Name:	Subscriber Name/DOB:	ID #:	Group #:

Who is your primary/referring doctor? _____

Pharmacy Name: _____ Location/Phone Number: _____

Medical History Update:

Has there been any change in your health since last appointment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:
Are you taking any new medications at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:
Do you have any allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:
Have you had any surgeries since your last visit? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:
Women: Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Due Date:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balances. I also authorize Surgical Associates to release any information required to process my claims.

Patient/Guardian Signature

Date