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: _____

Have you had your Flu Vaccination? **(please circle)** Yes No If so, when? _____

Medical History Update:

Has there been any change in your health since last appointment? ☐ Yes ☐ No If yes, please explain:	
Are you taking any new medications at this time? ☐ Yes ☐ No If yes, please explain:	
Do you have any allergies to medications? ☐ Yes ☐ No If yes, please explain:	
Have you had any surgeries since your last visit? ☐ Yes ☐ No If yes, please explain:	
Women: Are you pregnant? ☐ Yes ☐ 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

Surgical Associates of Myrtle Beach

Mark R. Borowicz, M.D., F.A.C.S.

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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