ALBUQUERQUE SURGICAL
consultants

Thank you for scheduling your appointment with Albuquerque Surgical Consultants. We look forward to seeing you on ______________________ at ___________ with Dr. Morris. Albuquerque Surgical Consultants is located at 4221 Montgomery Blvd NE in Granada Square.

Enclosed, you will find our registration forms, which need to be completed and brought to your appointment.

- Also bring any relevant **x-rays and medical records**.
- Be sure to list **all medications, dosages and drug allergies** on the attached form.
- Because we will likely need to obtain additional medical records, it is important you **sign the enclosed authorization form** as the releaser allowing us to request records from other physicians and facilities.
- If the doctor determines you require surgery, you will meet with one of our nurses/schedulers to set a date and time for your surgery. Please know your schedule so we can make these arrangements during your visit.

Insurance Claims

We are happy to file all insurance claims on our patients' behalf. To enable us to do so, please keep the following in mind:

Bring your insurance card with you to this visit. We will make a copy and return it to you. We participate with most, but not all medical insurance plans; it is your responsibility to understand your coverage and any changes in your benefits. Your signature on the enclosed release form allows our office to release your medical records to your insurance company, or to Medicare, so that they may pay us directly.

Referrals

Most managed care programs require a written referral from your primary care physician. **It is your responsibility to obtain a valid referral prior to your appointment with us.** If we do not receive it, you may have to accept responsibility for the full payment or you may have to reschedule once a referral is obtained.

Be prepared to settle your co-pay by bringing cash, check or Visa/MC.

For self pay patients, payment is expected at the time of service. Please be prepared to make at least a partial payment, or you may speak with our billing office to discuss arrangements.

Office Policies

All prescriptions should be requested during normal business hours. On-call physicians may not be able to accommodate you. Before phoning our office, make sure you are refilling a prescription that was initiated by this practice and that you have the phone number for your pharmacy handy. It may take up to 48 hours to process refills so plan ahead and request refills before you run out.

Albuquerque Surgical Consultants will complete one medical leave form per month, free of charge. Additional forms will require a $15.00 processing fee to be paid at the time forms are picked up. Processing can take 5-7 working days.

Due to the high demand for appointments, **we ask that you give us at least 24 hours notice if you need to cancel or reschedule**. A no show and no call may result in a $50 charge. Infrequently, surgical emergencies require our office to reschedule patient appointments. We apologize for any inconvenience.

PATIENT INFORMATION (Please Print)

ALBUQUERQUE SURGICAL consultants

Name____
First Middle Initial Last

Address ____ City ____________ State _____ Zip _______

Home Phone ( ) ______________ Work Phone ( ) ______________ Cell Phone ( ) ______________

DOB: ____/______/______ Male / Female SS#: _______/______/______ Marital Status S M W D

Employment Status (circle one) Employed Unemployed Retired Student Disabled

Referring Physician _________________________ Primary Care Physician _________________________

Emergency Contact ____________________ Relationship ______________ Phone ______________

PRIMARY INSURANCE ____

ID# _____________________________ Group# ___________________ Insured Party ________________

Relationship ____________ DOB ____/____/______ SS# ____/_____/_______ Employer ____________

Insured party address ____
(if different than above)

SECONDARY INSURANCE ____

ID# _____________________________ Group# ___________________ Insured Party ________________

Relationship ____________ DOB ____/____/______ SS# ____/_____/_______ Employer ____________

Insured party address ____
(if different than above)

(IF PATIENT IS A MINOR) **RESPONSIBLE PARTY INFORMATION**

Name ____ Relationship ________________

Address _______________________________________ City ____________________ State ______ Zip______

Home Phone ( )_______________ Work Phone ( )_______________ Cell Phone ( )_______________

Employer _______________________________ DOB _____/_____/_____ SS# _____/_____/_______

AUTHORIZATION/AGREEMENT I request that payment of authorized insurance benefits be made on my behalf to Albuquerque Surgical Consultants for any services furnished to me by the listed provider. I authorize any holder of medical information about me to release to my insurance carrier and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. I realize that I am responsible for the deductible, co-insurance, copay and non-covered services. In the event that there is no insurance coverage, or coverage is denied for any reason, I realize that I am responsible for all charges. Disclosed non-covered services are the responsibility of the patient.
A photocopy of this agreement shall be considered as effective and valid as the original.

______________________________________ ______________ ____________________
Signature of Patient/Responsible Party Date Relationship to patient

Albuquerque Surgical Consultants

Patient Acknowledgment of Receipt of Privacy Notice

The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, and/or in the performance of health care operations at Albuquerque Surgical Consultants. The Notice of Privacy Practices is also posted in the offices of Albuquerque Surgical Consultants at 4221 Montgomery Blvd NE, Albuquerque, NM 87109 and on the website at www.ABQsurgery.com.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment and/or health care operations of the practice. Albuquerque Surgical Consultants is not required to agree to the restrictions that I may request. However, if Albuquerque Surgical Consultants agrees to a restriction, the restriction is binding on Albuquerque Surgical Care and Dr. Sheri Morris.

I may obtain a revised notice of privacy practices by accessing the website, calling the office and requesting a revised copy be sent in the mail, or by asking for one at the time of my next appointment.

__________________________________ ______________________

Signature of Patient or Personal Representative Date

____

Printed Name of Patient or Personal Representative

Description of Personal Representative's Authority: ________________________________

For Office Use Only:

Signed form received by: ______________________________

Efforts to Obtain Acknowledgment: ______________________________________

____

ALBUQUERQUE SURGICAL consultants

Patient Name: ______________________________ Date of Birth: ____/____/________

Current Medications

Medication	Directions	Current?
	___ times daily	Yes / No
		Yes / No
		Yes / No
		Yes / No
		Yes / No
		Yes / No
		Yes / No
		Yes / No
		Yes / No

Allergies / Untoward reactions

Medication	Reaction

Height: ________________

Weight: _______________

Pharmacy: _________________________________ Pharmacy Phone Number: _________________

ALBUQUERQUE SURGICAL consultants

Patient:

Date: Referred by:

What is your reason for this visit?

____

____

How did you learn about our doctor?

____

____

SYMPTOMS Check (X) symptoms you currently have or have had in the **past year**.

GENERAL
[ ] Shaking chills
[ ] Persistent dizziness
[ ] Fainting
[ ] High fever
[ ] Persistent headache
[ ] Unintentional weight loss
[ ] Numbness
[ ] Drenching sweats
[ ] Easy bruising
[ ] Prolonged bleeding
[ ] Yellow jaundice
[ ] Arthritis

GASTROINTESTINAL
[ ] Decreased appetite
[ ] pain or distress after meals
[ ] Difficulty or pain swallowing
[ ] Stomach bloating
[ ] Change in bowel habits
[ ] Constipation
[ ] Diarrhea
[ ] Gas pains or cramps
[ ] Hemorrhoids
[ ] Nausea and/or vomiting
[ ] Rectal bleeding
[ ] Stomach pain

CARDIOVASCULAR
[ ] Chest pain or agina
[ ] High blood pressure
[ ] Rapid heart beat
[ ] Irregular heart beat
[ ] Low blood pressure
[ ] Poor circulation
[ ] Difficulty breathing
[ ] Swelling of ankles
[ ] Varicose veins
[ ] Rheumatic fever
[ ] Chronic cough
[ ] Pneumonia

HOSPITALIZATIONS/ OPERATIONS:

Year	Hospital	Reason

MEDICAL CONDITIONS: Check (X) conditions you have **ever** had or **have ever been** treated for:

[ ] Bleeding disorder
[ ] Anemia
[ ] Cancer (type:____________)
[ ] Diabetes
[ ] Heartburn or acid reflux
[ ] Liver disease
[ ] Hepatitis
[ ] Stomach ulcers
[ ] Blood in the stool
[ ] Breast lumps
[ ] Heart disease
[ ] High blood pressure
[ ] Artery blockage
location:___________
[ ] Pacemaker
[ ] Blood clots location:___________
[ ] Appendicitis
[ ] Hernia
[ ] Thyroid problems
[ ] AIDS or HIV positive
[ ] Kidney disease
[ ] Prostate problems
[ ] Stroke
[ ] TIA "mini-stroke"
[ ] Asthma
[ ] Emphysema
[ ] MRSA
[ ] Other (describe)
____

HEALTH MAINTENANCE: Please answer all questions that apply to you.

Have you ever had a blood or plasma transfusion? ___________________

When was your last PAP smear or Pelvic exam? _____________________

When was your last mammogram? ____________________

Have you been checked for blood in the stool? When? ____________________________

Have you had a colonoscopy before? Yes/No

If yes, date most recent _____________

Do you smoke tobacco? (please circle one) Never / Quit ______years ago / smoked for ___ years

Do you drink alcoholic beverages? (please circle one) Never / ____ drinks a week / month

FAMILY HISTORY: Are there any health conditions that run in the family?

[ ] Cancer and type: ______________________________

[ ] Diabetes

[ ] Heart disease or heart attack at an early age

[ ] Inherited disorders, type: ______________________________

Thank you for filling out this information. The information provided will become part of your **confidential** medical record and will assist your doctor in providing you the best possible care.

Acknowledgment

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: Date:

Reviewed by: Date:

If you need clarification about any part of this questionnaire, please ask the nurse or doctor.

Last Updated: Nov 6, 2008