UNIVERSITY GENERAL SURGEONS, P.C.
1932 Alcoa Hwy., Suite 270
Medical Office Building C
Knoxville, Tennessee 37920
(865) 251-4658

PATIENT INFORMATION

SOCIAL SECURITY # _____

FIRST NAME _____ MI _____

LAST NAME _____

SEX _____ DATE OF BIRTH _____

MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

CHECK ONE ☐ EMPLOYED ☐ RETIRED ☐ FULLTIME STUDENT ☐ OTHER

_____

HOME ADDRESS _____

_____

CITY _____ STATE _____ ZIP _____

E-MAIL _____

HOME PHONE _____

WORK PHONE _____

CELLPHONE _____

EMPLOYER _____

_____

PRIMARY INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

PRIMARY INSURED'S NAME _____

RELATIONSHIP _____ DOB _____ SOC.SEC.# _____

SECONDARY INSURANCE INFORMATION

INSURED'S NAME _____

RELATIONSHIP _____ DOB _____ SOC.SEC.# _____

EMERGENCY CONTACT

RELATIONSHIP _____

FIRST NAME _____ MI _____

LAST NAME _____

HOME PHONE _____

WORK PHONE _____

CELL PHONE _____

GUARANTOR / RESPONSIBLE PARTY

SOCIAL SECURITY # _____

FIRST NAME _____ MI _____

LAST NAME _____

SEX _____ DATE OF BIRTH _____

EMPLOYER _____

ADDRESS _____

_____

HOME ADDRESS _____

_____

CITY _____ STATE _____ ZIP _____

E-MAIL _____

HOME PHONE _____

WORK PHONE _____

CELL PHONE _____

Authorization to Release Information and Pay Benefits to The Physician's of University General Surgeons: I hereby assign all medical benefits to include any major medical benefits to The Providers of University General Surgeons. This assignment will remain in effect until revoked by me in writing. A photo copy of this agreement is to be considered as valid as an original. I understand that I am financially responsible for ALL charges whether or not paid by insurance. I further understand that I am responsible for ALL charges incurred by me when denied by my insurance because of a "Pre-Existing" condition or for going to an "Out-of-Network" provider. I hereby authorize said assignee to release all information necessary to secure payment. I have read, understand and agree to the above. By signing this agreement I understand that I (the above named patient) am responsible for any and all charges from services rendered by University General Surgeons, PC and Regional Trauma Services, PC. Our physician charges are completely separate from those billed to the patient by The University of Tennessee Medical Center (the hospital). Failure to abide by this agreement will result in my account being turned to collections where payment will be required immediately and in full.

_____ _____

SIGNATURE (PATIENT OR GUARDIAN) DATE

CHIEF COMPLAINT/LOCATION/CURRENT SYMPTOMS _____

_____

_____

PHARMACY NAME AND NUMBER _____

LIST ALL MEDICATIONS AND DOSES _____

_____

_____

_____

_____

MEDICATION ALLERGIES / INTOLERANCES TO: _____

_____

_____

ARE YOU ALLERGIC TO **IV** DYE? ☐ YES ☐ NO

ARE YOU ALLERGIC TO **LATEX**? ☐ YES ☐ NO

DO YOU SMOKE? ☐ YES ☐ NO

IF YES HOW MANY PACKS? _____

FORMER SMOKER? ☐ YES ☐ NO

DO YOU DRINK? ☐ YES ☐ NO

DO YOU USE ILLICIT DRUGS? ☐ YES ☐ NO

ARE YOU TAKING THE FOLLOWING? **IF YES WHY?**

ASPIRIN	☐ YES	☐ NO
COUMADIN	☐ YES	☐ NO
PLAVIX	☐ YES	☐ NO
PRADAXA	☐ YES	☐ NO
XARELTO	☐ YES	☐ NO

REASON FOR _____ OUTCOME _____

PAST MEDICAL HISTORY

CHECK ALL THAT APPLY

- ☐ ACNE ☐ AS
- ☐ ANXIETY DISORDER NOS
- ☐ BASAL CELL SKIN CANCER
- ☐ BLADDER INFECTIONS
- ☐ BLEEDING/CLOTTING DISORDER
- ☐ BLOOD CLOTS/ PULMONARY EMBOLISM / DVT
- ☐ BREAST CANCER
- ☐ CERVICAL CANCER
- ☐ CERVICAL (NECK) DISC DISEASE
- ☐ COLON CANCER DATE _____
- ☐ DECUBITUS ULCER
- ☐ DEMENTIA
- ☐ DEPRESSION
- ☐ DERMATITIS
- ☐ DIABETES
- ☐ DIALYSIS
- ☐ GALLSTONES
- ☐ GASTRIC CANCER
- ☐ GOITER
- ☐ HEART ATTACK
- ☐ HEART DISEASE
- ☐ HEART VALVE DISEASE
- ☐ HIATAL HERNIA
- ☐ HYPERTENSION (HIGH BLOOD PRESSURE)
- ☐ HYPOTHYROIDISM
- ☐ KIDNEY DISEASE
- ☐ KIDNEY STONES
- ☐ LUMBAR DISC DISEASE
- ☐ LUNG CANCER
- ☐ MELANOMA - SKIN
- ☐ MIGRAINE HEADACHE
- ☐ MULTIPLE SCLEROSIS
- ☐ OVARIAN CANCER
- ☐ OVARIAN CYST
- ☐ PARALYSIS
- ☐ PARKINSON'S DISEASE
- ☐ PSORIASIS
- ☐ PULMONARY DISEASE/COPD/ASTHMA
- ☐ QUADRIPLEGIA
- ☐ SEIZURES
- ☐ SKIN CANCER
- ☐ SKIN ULCER - CHRONIC
- ☐ SQUAMOUS CELL CARCINOMA
- ☐ STOMACH ULCER
- ☐ STROKE
- ☐ UTERINE CANCER
- ☐ UTERINE FIBROIDS
- ☐ OBSTRUCTIVE SLEEP DISORDER

HAVE YOU HAD:

- ☐ COLONOSCOPY DATE _____
- ☐ MAMMOGRAM DATE _____
- ☐ PAP SMEAR DATE _____
- ☐ MASTECTOMY DATE _____
- ☐ HYSTERECTOMY DATE _____
- ☐ COLECTOMY DATE _____

LIST PAST SURGICAL HISTORY _____

_____

_____

_____

FAMILY PHYSICIAN / PCP. ADDRESS PHONE NUMBER

_____ _____

SIGNATURE (PATIENT OR GUARDIAN) DATE