SURGICAL ASSOCIATES OF OPELOUSAS

New Patient Welcome Packet

Inside you will find the paperwork that is needed for your visit with us. In order to reduce your waiting time please fill out the information prior to your clinic appointment and **BRING THIS WITH YOU** to your appointment. Please bring ALL CURRENT MEDICATIONS with you. If x-rays have been done at an outside hospital, please have them sent to us or bring them with you so that they can be reviewed during your appointment.

We DO NOT do procedures on the same day as your consultation. Procedures will be scheduled after you have been examined and evaluated.

Unfortunately, emergencies are a common part of general surgery and this will disrupt our daily schedules. We try our best to stay on time but if we are called away during office hours please be patient with us; one day it maybe you or your family member that we are attending to.

Sincerely,

Surgical Associates of Opelousas

Lafayette

Location of SAO

We are located near *Our Lady of Lourdes Heart Hospital* ***1103 Kaliste Saloom Rd, Ste 200.*** This is between the heart hospital and the Lafayette Surgical Specialty Hospital.

PHONE -- 337.942.7192

Opelousas

Location of SAO

We are located near *Opelousas General Hospital* at ***703 East Prudhomme Street.*** This is on the right side of the cancer center and across the street from the Opelousas Catholic baseball field. **PHONE --**

Acct #_____

SURGICAL ASSOCIATES OF OPELOUSAS

PATIENT INFORMATION

Patient:_____ Title: Mr./Mrs./Other:_____ Suffix: Jr/Sr/Other:_____
(Last / First / Middle)

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

Home Ph.:_____ Work Ph.: _____ Cell Ph.: _____ Other Ph.:_____

Social Security #_____ Date of Birth:_____ Sex: M or F

Employment Status: (circle one) Fulltime Self Employed Part time Not Employed Unknown Retired Military Active Employer:_____

Marital Status: Married Single Widowed Divorced (circle one) Student: Full or Part time (circle one)

Referred By:_____ PCP:_____

Is this an accident or Injury? Y or N Date of injury:_____

Work Related? *Y or N ** If Y Responsible Party should be Employer.* Date symptoms began:_____

Emergency Contact Name: _____ Relationship:_____

Phone: Home:_____ Work:_____ Cell:_____

Are you currently a Hospice or Home Health Care patient or are you in a Nursing Home or Skilled Nursing Facility? Y or N
If 'Y', request a Facility Information Form and ask about an ABN form.

RESPONSIBLE PARTY INFORMATION

IF OTHER THAN PATIENT, SEND STATEMENT/BILL TO:

Responsible Party:_____ Title: Mr./Mrs./Other:_____ Suffix: Jr/Sr/Other:_____
(Employer Info if work related) (Last / First / Middle)

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

Home Ph.:_____ Work Ph.:_____ Cell Ph.:_____ Resp Pty Date of Birth:_____

Social Security #_____ Resp Pty Sex: M or F Relationship to Patient: _____

Employment Status: (circle one) Fulltime Self Employed Part time Not Employed Unknown Retired Military Active Employer:_____

Marital Status: Married Single Widowed Divorced (circle one)

INSURANCE INFORMATION

Scan/Copy Card

PRIMARY: _____

*Policy #:*_____ *Grp#*_____

Insured:_____ DOB:_____

Relationship to Patient: Self Child Mate Other (circle one)

SECONDARY:_____

*Policy #:*_____ *Grp#*_____

Insured:_____ DOB:_____

Relationship to Patient: Self Child Mate Other (circle one)

By signing this, I hereby acknowledge Thomas Castille, M.D., Louis M. Corne, Jr., M.D. Eric P. Amy, M.D. and Salvador H. Vazquez, M.D. (PRACTICE) has the right to use and disclose protected health information (PHI) for treatment, payment and health care operations, and that I have received the *Notice of Privacy Practices for Protected Health Information (NOPP).* I understand I have the right to restrict how protected health information is used or disclosed, and that the PRACTICE is not required to agree to any restriction, but if an agreement is reached, the PRACTICE is bound by the agreement.

_____ _____
Signature Date

I hereby authorize Thomas Castille, M.D., Louis M. Corne, Jr., M.D. Eric P. Amy, M.D. and Salvador H. Vazquez, M.D. to evaluate and recommend any testing and/or additional treatment.
I understand I have the right to refuse any such recommendations/treatment.

_____ _____
Signature Date

I understand that charges **not covered** by Medicare, Medicaid or Managed Care will be the patient's responsibility. I verify this information is true and accurate as of the below indicated date.

I hereby authorize the attached insurance companies to pay directly to Thomas Castille, M.D., Louis M. Corne, Jr., M.D., Eric P. Amy, M.D. and Salvador H. Vazquez, M.D. benefits due on my behalf, if any, as provided in the above unexpired policy. I will pay all charges in excess of whatever sums may be allowed by my insurance and acknowledge outstanding amounts due from me, greater than 30 days, will be assessed a finance charge of 1.5% per month.

_____ _____
Signature Date

SURGICAL ASSOCIATES OF OPELOUSAS

Acct #_____

PATIENT INFORMATION

Patient:_____ Title: Mr./Mrs./Other:_____ Suffix: Jr/Sr/Other:_____
Last First Middle

If Hospice/HHA/NH/SNF patient and answered 'Y'es on Acquaintance Form, complete below and ask about an ABN form. Please ask if you have any questions.

FACILITY INFORMATION

Type: (circle one) Hospice Home Health Nursing Home Skilled Nursing Facility

Facility Name: _____ Contact Name:_____
Last First Middle

Mailing Address: _____ _____ _____ _____
City State Zip

Phone: _____

OFFICE USE ONLY
Provide ABN form for all services.

If currently a Home Health patient, all charges must be paid for prior to rendering services or the patient must be redirected to the HHA facility for care.

Refer to **User Guide: SNF/Home Health/Hospice Billing Medicare & LA Medicaid**

Surgical Associates of Opelousas
PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct by treatment and follow-up among the multiple Healthcare providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third-party payers.

- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address provided on the notice to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that Louis M. Corne, Jr., MD, or Eric P. Amy, MD, Salvador Vazquez, MD, or
Thomas A. Castille, MD restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Signature: _____ Date: _____

Print Name: _____

Relationship if other than Patient: _____

Surgical Associates of Opelousas

Who referred you here today? _____

Why are you here today? _____

Who is your primary physician? _____

Do you have any drug allergies? _____

What medications do you take?

_____

_____

_____

_____

_____

_____

_____

_____

Surgical Associates of Opelousas

NAME: _____

REVIEW OF SYSTEMS: PLEASE PUT A CHECK FOR THE SYMPTOMS YOU ARE CURRENTLY EXPERIENCING.

CONSTITUTIONAL

- ❑ Appetite Change
- ❑ Chills
- ❑ Fever
- ❑ Fatigue
- ❑ Weakness
- ❑ Weight Change
- ❑ Weight Loss

EYES

- ❑ Blind
- ❑ Blurred vision
- ❑ Double vision
- ❑ Eye Pain
- ❑ Worsening Eyesight

ALLERGIES

- ❑ Animal
- ❑ Drug
- ❑ Environmental
- ❑ Food
- ❑ Seasonal

NEUROLOGICAL

- ❑ Balance Problems
- ❑ Disoriented
- ❑ Dizzy
- ❑ Headache
- ❑ Leg/arm weakness
- ❑ Memory Loss
- ❑ Numbness/Tingling
- ❑ Speech Problems
- ❑ Tremors

ENDOCRINE

- ❑ Sugar Diabetes
- ❑ Thirsty
- ❑ Thyroid Problem
- ❑ Tired/sluggish
- ❑ Too hot/cold

GASTROINTESTINAL

- ❑ Abdominal pain
- ❑ Abdominal cramps
- ❑ Reflux
- ❑ Bloody Stools
- ❑ Constipation
- ❑ Diarrhea
- ❑ Nausea/vomiting
- ❑ Hemorrhoids
- ❑ Indigestion/Heartburn

CARDIOVASCULAR

- ❑ Chest Pain
- ❑ Dyspnea on exertion
- ❑ Edema
- ❑ Irregular Heart Beat

SKIN/INTEGUMENTARY

- ❑ Acne
- ❑ Boils
- ❑ Moles
- ❑ Itching
- ❑ Rash

MUSCULOSKELETAL

- ❑ Back Pain
- ❑ Joint Pain
- ❑ Muscle cramps
- ❑ Muscle weakness

ENT

- ❑ Ear Infections
- ❑ Sinus trouble
- ❑ Sore Throat
- ❑ Deafness

GENITOURINARY

- ❑ Bedwetting
- ❑ Blood in urine
- ❑ Burning on urination
- ❑ Erection problems
- ❑ Bladder stones
- ❑ Leaking urine

RESPIRATORY

- ❑ Asthma Attack
- ❑ Cough
- ❑ Shortness of Breath
- ❑ Wheezing

HEMAT/LYMPHATIC

- ❑ Swollen Glands
- ❑ Blood Clotting Problem
- ❑ Bleeding problems
- ❑ Bruising

PSYCHOLOGICAL

- ❑ Do you feel anxious?
- ❑ Do you feel depressed?

VS: Temp: ____ RESP: _____ HR: _____

BP: _____ WT: _____

Surgical Associates of Opelousas

NAME: _____

PAST MEDICAL HISTORY: PUT A CHECK NEXT TO THE FOLLOWING THAT YOU HAVE BEEN DIAGNOSED WITH.

CARDIOVASCULAR

- ❑ Anemia
- ❑ Aneurysm
- ❑ Arrhythmia
- ❑ Atrial Fibrillation
- ❑ Congestive Heart Failure
- ❑ Coronary Artery Disease
- ❑ Hypertension
- ❑ Mitral Valve Prolapse
- ❑ Sickle Cell Anemia

ENDOCRINE

- ❑ Diabetes Mellitus
- ❑ Gout
- ❑ Hyperthyroid
- ❑ Hypothyroid

GENERAL

- ❑ High Cholesterol
- ❑ O b e s i t y

GASTROINTESTIONAL

- ❑ Gallstones
- ❑ Chron's/Colitis
- ❑ Diverticulitis
- ❑ GERD/Reflux
- ❑ Hepatitis
- ❑ Irritable Bowel
- ❑ Pancreatitis
- ❑ Stomach Ulcer

GENITOURINARY

- ❑ AIDS/HIV
- ❑ BPH
- ❑ Renal Failure
- ❑ HPV
- ❑ Impotence
- ❑ Interstitial Cystitis
- ❑ Kidney Cancer
- ❑ Kidney Stones
- ❑ Polycystic Kidneys
- ❑ Testicle Cancer
- ❑ Prostate Cancer
- ❑ Bladder Cancer

HEENT

- ❑ Blind
- ❑ Cataracts
- ❑ Deafness
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Sinusitis
- ❑ Ringing in ear (tinitus)

MUSCULOSKELETAL

- ❑ Arthritis
- ❑ Carpel tunnel
- ❑ Fibromyalgia

Neuro/Psych

- ❑ ADD
- ❑ Alcoholic
- ❑ Alzheimer's Disease
- ❑ Anxiety
- ❑ Bipolar
- ❑ Depression
- ❑ Multiple Sclerosis
- ❑ Parkinson's
- ❑ Polio
- ❑ Seizures
- ❑ Spinal Cord Injury
- ❑ Stroke/CVA

RESPIRATORY

- ❑ Asthma
- ❑ Bronchitis
- ❑ COPD
- ❑ Emphysema
- ❑ Pulmonary Emboli
- ❑ TB
- ❑ Sleep Apnea

TUMORS

- ❑ Skin Cancer
- ❑ Brain Tumor
- ❑ Cervical/Uterine
- ❑ Colon Cancer
- ❑ Stomach Cancer
- ❑ Throat Cancer
- ❑ Lung Cancer
- ❑ Lymphoma
- ❑ Ovarian Cancer
- ❑ Pancreatic Cancer
- ❑ Rectal Cancer
- ❑ Sarcoidosis

Surgical Associates of Opelousas

NAME:

PAST SURGICAL HISTORY

List and date all surgeries: _____

_____

_____

_____

SBE PROPHYLAXIS

Do you have to take antibiotics prior to dental or surgery procedures due to a heart condition?
No
Yes, please specify_____

OB/GYN HISTORY

Last menstrual period _____
Number of pregnancies _____
Number of deliveries _____
Age of first period _____
Age of menopause _____
Do you have regular periods?_____
Are you sexually active? _____
Prior abnormal pap smear?_____

FAMILY HISTORY

Are you adopted? Yes/No

Does anyone in your family have the following conditions?

If so indicate if father, mother, aunt, uncle, brother, sister, grandfather, or grandmother

Bedwetting _____
Bladder cancer_____
Breast cancer _____
Other cancer(what type?) _____
Cervical cancer _____
Colon cancer _____
COPD(lung disease) _____
Diabetes_____
Heart Attack _____
High blood pressure _____
Kidney cancer _____
Kidney disease (What type?) _____
Ovarian cancer _____
Parkinson's _____
Stroke _____
TB _____
Uterine cancer _____

Surgical Associates of Opelousas

NAME:
SOCIAL HISTORY

MARITAL STATUS:
MARRIED
SINGLE
DIVORCED
WIDOW
LIFE PARTNER

CHILDREN: YES/NO How many?

OCCUPATION:

ALCOHOL CONSUMPTION
Do you drink alcohol? YES/NO
Social YES/NO
How many drinks per day?

SMOKING HISTORY:
Do you smoke presently? YES/NO

How many packs a day?

How many years have you smoked?

Do you use smokeless tobacco? YES/NO

Did you smoke in the past? YES/NO

How many packs a day?

For how many years?

Number of years since you quit?

DRUG USE:
Do you use recreational drugs? YES/NO
What type?

CAFFEINE:
Do you drink caffinated beverages? YES/NO
How many a day?

FOREIGN TRAVEL:
Have you been to a foreign country recently?
Where?