

TRI-COUNTY SURGICAL ASSOCIATES, P.A.

PATIENT INFORMATION FORM

Dr. Thomas Litton

Dr. Jeffrey Lafond

Patient Information

Name: _____ SS# _____
Address _____ City _____ State _____ Zip _____
Phone: Home _____ Cell _____ Date of Birth _____ Age _____ Race _____
Marital Status: Married _____ Single _____ Divorced _____ Separated _____
Student status: ___ Full ___ Part ___ N/A ___ School _____ Phone _____
Employment: ___ Full ___ Part ___ None ___ Employer _____ Phone _____
Emergency Contact _____ Phone _____ Relationship _____

Responsible Party (if different from patient)

Name _____ SS# _____
Address _____ City _____ State _____ Zip _____
Date of Birth _____ Employer _____ Phone _____

Other Patient Information

Referred by: _____ Family Physician _____
Please list all prescription and over the counter medicines you are currently taking (include dose): _____
Reason for today's visit _____
Are you taking or have you taken Aspirin or blood thinners? _____ Current Weight _____
Medication or other allergies _____
Date and location of last mammogram: _____ Results _____
Date and location of last colonoscopy: _____ Results _____
Date of Last Gynecological Exam: _____ Results _____
Number of Pregnancies _____ Live Births _____ Abortions _____
Do you currently or have you ever used: (please check): Alcohol ___ Yes ___ No ___ Date Quit _____
Tobacco ___ Yes ___ No ___ Date Quit: Drugs: ___ Yes ___ No ___ Date Quit _____

Past Medical History *(Please Check All That Apply)*

Childhood Illness _____ Stomach Problems _____ Seizures _____ Heart Disease _____ Dizziness _____
 Arthritis _____ Lung Disease _____ High Blood Pressure _____ Thyroid Problems _____
 Kidney Disease _____ Cancer _____ Diabetes _____ Other _____

Please List any Previous Hospitalizations or Operations

DATE	TYPE OF OPERATION	HOSPITAL & PHYSICIAN(S)

Family History: *(Please check all that apply)*

High Blood Pressure _____ Kidney Disease _____ Asthma _____ Heart Disease _____
 Psychiatric illness _____ Liver Disease _____ Cancer (location) _____
 Other _____

Please check any conditions that apply to you (the patient)

Bleeding Problems _____ Tuberculosis _____ Laxative Use _____ Weight Loss/Gain _____
 Shortness of Breath _____ Rectal Bleeding _____ Sexually Transmitted Disease _____
 Use of Antibiotics Prior to Dental Work _____ Change in Bowel Habits _____ Ulcers _____
 Psychiatric Illness _____ Chest Pain _____ Heart Murmur _____ Heartburn _____
 History of Breast Lumps _____ Chronic Cough _____ HIV/AIDS _____
 Hepatitis _____ Bladder Problems _____ Problems with Anesthesia _____

Insurance Information Primary

Name of Insurance Company: _____ ID# _____ Grp# _____

Member/Policyholder _____ DOB _____

Insurance Company Address and Telephone Number: _____

Secondary Insurance Company: _____ ID# _____ Grp# _____

Member/Policyholder _____ DOB _____

Insurance Co Address and Telephone Number: _____

Communication Regarding Your Healthcare

Tri-County Surgical Associates has your permission to release/discuss your health information with the following individuals/organizations for the following dates of service, range of time, or events(s): From (MM/DD/YY) _____ To (MM/DD/YY) _____

Name (Physician, family, etc); Address; Phone/Fax; Relationship:

Authorization, Assignment of Benefits, and Referral Medical Release

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly to Tri-County Surgical Associates for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this form shall be considered as effective and as valid as the original. I have been provided a copy of the Tri-County Surgical Associates Notice of Information Practices.

Signed: _____ Date: _____