CAPITAL SURGICAL ASSOCIATES

PLEASE FILL OUT EACH SECTION COMPLETELY- THANK YOU

PATIENT'S LEGAL NAME	DATE OF BIRTH	SEX ☐ M ☐ F	AGE	MARITAL STATUS
MAILING ADDRESS	CITY	STATE/ZIP CODE		
PRIMARY PHONE#	CELL PHONE#	WORK PHONE #	PREFERRED CONTACT METHOD	
PATIENT'S EMPLOYER	EMPLOYER ADDRESS	SOCIAL SECURITY #		
RACE	ETHNICITY ☐ HISPANIC ☐ NON-HISPANIC	LANGUAGE		
WHO IS YOUR REFERRING PHYSICIAN?	WHO IS YOUR PRIMARY CARE PROVIDER?	EMAIL		

SPOUSE'S NAME (if married)	SPOUSE'S SSN #	DATE OF BIRTH
SPOUSE'S EMPLOYER	SPOUSE'S PHONE#	
FATHER'S NAME (if minor)	FATHER'S SSN #	DATE OF BIRTH
FATHER'S EMPLOYER	FATHER'S CONTACT PHONE#	
MOTHER'S NAME (if minor)	MOTHER'S SSN #	DATE OF BIRTH
MOTHER'S EMPLOYER	MOTHER'S CONTACT PHONE#	

PLEASE CIRCLE ONE: ☐ INSURANCE ☐ WORKER'S COMP ☐ AUTO ☐ OTHER ☐ SELF-PAY ☐ MEDICARE ☐ MEDICAID

WERE YOU INJURED AT WORK? ☐ YES ☐ NO

WERE YOU INJURED IN AN AUTO ACCIDENT? ☐ YES ☐ NO

DO YOU HAVE A LIVING WILL OR ADVANCED CARE PLAN? YES☐ NO☐

WHO IS YOUR SURROGATE DECISION MAKER? _____

WHICH PHARMACY DO YOU USE?

NAME:_____ LOCATION:_____

INSURANCE COMPANY NAME (PRIMARY)			**INSURANCE COMPANY NAME** (SECONDARY)		
ADDRESS		PHONE#	ADDRESS		PHONE#
ID#		GROUP#	ID#		GROUP#
POLICYHOLDER	BIRTH DATE	RELATIONSHIP	POLICYHOLDER	BIRTH DATE	RELATIONSHIP

EMERGENCY CONTACT INFORMATION

NEAREST FRIEND/RELATIVE NOT LIVING WITH YOU	
RELATIONSHIP	PHONE #

I authorize Capital Surgical Associates to render treatment. I authorize Capital Surgical Associates to release/obtain any medical records/x-rays from any medical care providers and my insurance carrier to facilitate processing of my claims. I authorize my insurance carrier to pay all benefits directly to Capital Surgical Associates. This authorization shall continue to be in force and effect until revoked in writing by me. By signing, I acknowledge that I am ultimately responsible for any and all charges incurred by this office.

SIGNATURE (PATIENT, OR PARENT/GUARDIAN IF UNDER 18)	DATE

CAPITAL SURGICAL ASSOCIATES

DESIGNATION FOR RELEASE OF MEDICAL INFORMATION TO A FAMILY MEMBER, FRIEND OR LEGAL REPRESENTATIVE

Introduction

It is the physician's responsibility to ensure that the physician-patient relationship is confidential. The Health Portability and Accountability Act (HIPAA) will allow physicians to use their professional judgment on disclosing certain personal health information to family, friends, etc. without an authorization. This form is an aid to the physicians in making a determination on disclosing such information. Capital Surgical Associates realizes that there are times when you, the patient, may want another person to be knowledgeable about your medical condition or medical needs. Your doctor wants you to be able, if you so desire, to name a person to whom you want the office staff to speak with about your medical condition. To enable that, we would ask that you complete the form listed below. Please note the following points:

- If you designate no one, Capital Surgical Associates will not release information to any family member, friend or legal representative.
- This Release of Information expires 1 year from the date it is signed.
- This designation is valid until you cancel it in writing.

Designation Statement

I, _____, designate the following person(s) to be able to speak to a physician at Capital Surgical Associates, or other staff member, should it be necessary, on my behalf. I hereby give permission to Capital Surgical Associates through its physicians and staff to release to my designee(s) any information about my medical condition or medical needs or the status of my account and I release Capital Surgical Associates its physicians, and staff, from any claim of confidentiality in connections with the release of this information.

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

Patient's Name:_____ Patient's Signature_____

Date: _____

I decline to designate another person to speak with my physician or clinical staff.

Patient's signature:_____ Date:_____

CAPITAL SURGICAL
ASSOCIATES

INJURY QUESTIONNAIRE

Name:_____

Was the condition a result of an injury: Yes ☐ No ☐

Was this related to an Auto Accident: Yes ☐ No ☐

If no to both of the questions above, skip the questions below

If yes, were you the: ☐ Driver ☐ Passenger Were you at fault of the accident? Yes ☐ No ☐

Have you filed a claim with your auto insurance: Yes ☐ No ☐

Was this related to an on the job injury: Yes ☐ No ☐

If yes, name and number of your employer:_____

_____

Did you fill out an injury report with your employer? Yes ☐ No ☐

What date did the injury happen:_____

Where (location) did the injury happen:_____

_____

What activity were you doing at the time of the injury:_____

_____

Details of injury, please be specific_____

_____

_____

_____

Signature_____Date:_____

CAPITAL SURGICAL ASSOCIATES

MEDICAL HISTORY FORM

Name: _____ **DOB:** _____ **Date:** _____

PATIENT PROFILE:

Age:	Marital Status:	Occupation:
Height:	Weight:	BMI:
Do you drink alcohol: Yes ☐ No ☐	If so how much?	
Do you use tobacco? Yes ☐ No ☐ Never ☐	If so how much?	
Have you ever used tobacco?		
Have you used recreational drugs within 30 ☐ 90 ☐ days or over a year		
What type of drug?		

What other physicians do you see? (Full names, please) _____

_____

Date of last exam: _____ Date of EKG: _____ Date of blood tests: _____

Do you have a living will or advanced care plan? ☐ Yes ☐ No

Who is your surrogate decision maker? _____

Have you had an influenza (flu) shot? ☐ Yes ☐ No If yes, when? _____

If no, why? ☐ Declined ☐ Allergic ☐ Not Available

Have you had the COVID-19 Vaccine? ☐ Yes ☐ No If yes, when? _____

Have you had a colonoscopy? ☐ Yes ☐ No If yes when and where? _____

_____

PAST MEDICAL HISTORY: (Check all that apply and explain)

☐	High Blood Pressure	☐	Reflux
☐	Heart Attack	☐	Strokes
☐	Congestive Heart Failure	☐	Seizures
☐	Blood Transfusion	☐	Glaucoma
☐	Angina	☐	Psychiatric problems
☐	Heart murmur	☐	Depression
☐	Irregular heartbeat	☐	Anxiety Reactions
☐	Lung disease (specify)	☐	Anemia
☐	Shortness of breath	☐	Blood Clots
☐	Asthma	☐	Muscle Disease
☐	Sleep Apnea	☐	Arthritis
☐	Diabetes	☐	Urinary Incontinence
☐	Liver Disease (specify)	☐	HIV/ AIDS
☐	Kidney Disease (specify)	☐	Ulcers
☐	Thyroid Disease	☐	Hepatitis
☐	Cancer (specify)	☐	Other

Name: _____

PAST SURGICAL HISTORY:

Surgery	Year	Surgery	Year

ALLERGIES: List allergies and the reaction you have. If no allergies, write **NONE.**

Allergy	Reaction

Which pharmacy do you use?

Name: _____ Location: _____

MEDICATIONS: List ALL prescriptions, over the counter medications, and herbal supplements you are currently taking.

Medication	Dosage	Times per day	Reason for use

OFFICE USE:

History updated: _____
History updated: _____

Vital Signs:

Date: _____ BP: _____ Pulse: _____
Date: _____ BP: _____ Pulse: _____
Date: _____ BP: _____ Pulse: _____

Reviewed by:

Date: _____ Clinical Staff: _____ MD: _____
Date: _____ Clinical Staff: _____ MD: _____
Date: _____ Clinical Staff: _____ MD: _____