Surgical Consultants, PLLC
1030 Harrington Street, Ste 302A
Mt. Clemens, MI 48043
Phone: 586-759-2005 Fax: 586-759-2636

Bariatric/ General Surgery
Mandip S. Atwal, D.O. FACOS
Carl M. Pesta, D.O. FACOS

Patient Information

Name: _____
DOB: _____
SS #: _____
Phone #: _____
Email: _____

Primary/ Referring Doctor: _____
Dr. Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ Fax Number: _____

Responsible Party (if patient is a minor)
Person Responsible for Fees: _____
Relationship to Patient: _____ DOB: _____ SS # _____
Address: _____ City: _____ State: _____ Zip Code: _____

Insurance (Please provide copy of your insurance card(s) along with the following information)
Insured's Name: _____ Insured's DOB: _____

Emergency Contact:
Person (not living with you) to contact in an emergency: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Home #: _____ Cell #: _____ Work #: _____

Employer:
Address: _____ City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

Pharmacy Name: _____
Pharmacy Phone #: _____

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By Signing below, I _____ Authorize Surgical Consultants and, or acknowledge receipt of:

A.) To consult my other physicians for exchange of medical information.

B.) Have read and agree to the assignment of benefits & payment policy.

C.) Have read and agree to the Telephone Consumer Protection Act.

D.) Have read and acknowledge receipt of the HIPPA Act.

E.) Give authorization to leave a message at the numbers provided.

F.) Give authorization to call my work if necessary.

G.) Have read and agree to the financial agreement for payment of fees.

H.) Education on Prescription Opioids: What you need to know.

Patient Signature OR Responsible Party: _____

Date: _____

Witness: _____

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ACKNOWLEDGMENT OF RECEIPT

Joint Notice of Privacy Practices HIPPA

If you have any questions regarding the information contained in Surgical Consultants Joint Notice of Privacy Practices, please contact Surgical Consultants Chief Compliance Officer at (586) 759- 2005.

I consent to allow Surgical Consultants, PLLC to use or disclose my protected health information for treatment, payment and health care operations.

I consent to allow Surgical Consultants, PLLC to disclose my protected health information for treatment activities of another health care provider.

I consent to allow Surgical Consultants, PLLC to disclose my protected health information to another covered entity or to another health care provider for the payment activities of the entity that receives the information.

I consent to allow Surgical Consultants, PLLC to disclose protected health information to another covered entity for health care operations activities, proved that Surgical Consultants, PLLC and the other covered entity has or had a relationship with the below named patient. The disclosure must be for treatment, payment, or healthcare operations or for the purpose of health care fraud and abuse detection or compliance. I have been given a copy of The Notice of Privacy for Surgical Consultants, PLLC.

Please name anyone you would like Surgical Consultants, PLLC to release medical information to:

_____

If you wish to revoke permission, it will be your responsibility to notify the office.

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Financial Agreement for Payment of Fees

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

I understand I am responsible for ant services not payable by my insurance, and if my account must be sent to a collection agency, I will be responsible for all collection costs and legal fees incurred.

- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverage have Out-of- Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.
- I have read the financial policies contained above, and my signature below serves as acknowledgment of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Patient Signature: _____

Patient Name Printed: _____

Date: _____ Witness: _____

Patient Name: _____ **Date:** _____

Referred by: _____

Primary Care Physician: _____

Chief Complaint: _____

(REASON FOR YOUR VISIT TODAY)

PATIENT SOCIAL HISTORY:

Age: _____ Sex: M / F Race: White Black Other: _____

Job/ Type of Employment: _____

Use of Alcohol: Never Rarely Moderately Daily

Use of Tobacco: Never Previously but quit, date: _____ Packs Per Day: _____

Use of Illicit Drugs: Never Type/ Frequency: _____

PATIENT MEDICAL HISTORY:

Diabetes…….. NO/ YES	Convulsion…..... NO/ YES	Asthma……..... NO/ YES
Hypertension…... NO/ YES	Bruising Tendency…. NO/ YES	Arthritis…….. NO/ YES
Cancer…….. NO/ YES	Venereal Disease…...NO/ YES	Heart Trouble…..... NO/ YES
Acute Infections.. NO/ YES	Hereditary diseases... NO/ YES	Gout……..NO/ YES

Other History: _____

Surgical Procedures:

_____

_____

_____

Hospitalizations (non-surgical) Date:

_____

_____

_____

Family Med History:

	Age:	Diseases:	If Deceased, Cause/ Age:
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
Sisters	_____	_____	_____
M Grndmther	_____	_____	_____
M Grndfther	_____	_____	_____
P Grndmther	_____	_____	_____
P Grndfther	_____	_____	_____

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Name: _____ DOB: _____

Please fill out your prescribed medications AND any over the counter medicines or herbal supplements.

Name of Medication:	Strength:	Date:	Date:	Date:	Date:	Date:	Date:
	Dr. Initials						

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CONSTITUTIONAL SYSTEMS:

Good general health……	NO	YES
Recent weight change……	NO	YES
Fever……	NO	YES
Fatique……	NO	YES
Headaches……	NO	YES

ALLERGIC/ IMMUNOLOGIC:

Penicillin……	NO	YES
Other antibitoics?	NO	YES
Codeine……	NO	YES
Demerol……	NO	YES
Other Narcotics?	NO	YES
Novocain……	NO	YES
Other Anesthetics?	NO	YES
Aspirin……	NO	YES
Tetanus Antitoxin……	NO	YES
Iodine……	NO	YES
Methiolate……	NO	YES
Other Antiseptics?	NO	YES
Other drugs/ Meds?	NO	YES
Please List:_____		
Latex Allergy?	NO	YES
Food Allergies?	NO	YES

ENDOCRINE/ NECK:

Glandular problem……	NO	YES
Hormone problem……	NO	YES
Excessive thirst……	NO	YES
Excessive urination……	NO	YES
Heat intolerance……	NO	YES
Cold intolerance……	NO	YES

NEUROLOGICAL/ HEAD:

Frequent headaches……	NO	YES
Recurring headaches……	NO	YES
Lightheadedness……	NO	YES
Dizziness……	NO	YES
History of head injury……	NO	YES
Blurred vision……	NO	YES
Double vision……	NO	YES

RESPIRATORY:

Chronic cough……	NO	YES
Frequent cough……	NO	YES
Shortness of breath……	NO	YES
Asthma/ Wheezing……	NO	YES

INTEGUMENTARY (SKIN/ BREAST):

Rash……	NO	YES
Itching……	NO	YES
Change in skin color……	NO	YES
Breast Pain/ Lump……	NO	YES
Breast Discharge……	NO	YES

GASTROINTESTINAL:

Loss of Appetite……	NO	YES
Change in bowel habits……	NO	YES
Nausea……	NO	YES
Vomiting……	NO	YES
Frequent diarrhea……	NO	YES
Painful bowel movements……	NO	YES
Constipation……	NO	YES
Rectal Bleeding/ Blood in stool……	NO	YES
Jaundice (yellow)……	NO	YES
Abdominal pain……	NO	YES
Heartburn……	NO	YES
Peptic Ulcer(stomach/ duodenal……	NO	YES

GENITOURINARY:

Frequent urination……	NO	YES
Burning with urination……	NO	YES
Painful urination……	NO	YES
Blood in urine……	NO	YES
Kidney Stones……	NO	YES
Male- Testicular Pain……	NO	YES
Female- # Pregnancies_____		
Female- # Miscarriages_____		

CARDIOVASCULAR:

Chest pain……	NO	YES
Angina Pectoris……	NO	YES
Palpitation……	NO	YES
Swelling of feet……	NO	YES
Swelling of ankles……	NO	YES
Swelling of hands……	NO	YES

MUSCULOSKELETAL:

Weakness of muscles……	NO	YES
Muscle pain/ cramps……	NO	YES
Cold extremities(hands/feet)……	NO	YES
Back pain……	NO	YES
Last Pap Smear_____		
Last Colonoscopy_____		
Last Mammogram_____		