LAFAYETTE
Surgical Clinic
A UNITY HEALTHCARE PARTNER

Date:____________________

Patient Name:____Date of Birth:_______________________
Primary Care / Family Doctor:_________________________Physician referring you to this clinic:____________________
Surgical Problem / Injury / Illness:______________________Part of body affected:_________________________________
Date of onset of current problem:____
Has this problem been evaluated or treated elsewhere? □ YES □ NO If yes, where?_______________________________
Describe how the problem/ injury/ illness occurred:____
____

PAST MEDICAL HISTORY
Currently being treated:
____
____
____
____
____

Treated in the past:
____
____
____
____

MEDICATIONS
Prescriptions: (Please include frequency & dose or attach list.)
____
____
____
____
____

Over the counter / herbal:
____
____
____
____

PAST SURGICAL HISTORY
Please list all previous operations:
____
____
____
____
____
____
____

ALLERGIES
Please list medication allergies / reaction:____
Are you allergic to latex? □ YES □ NO

SOCIAL HISTORY
Do you live alone? □ YES □ NO
What is your occupation?____
Does your occupation involve strenuous labor? □ YES □ NO
Do you consume alcohol? □ YES □ NO If so, how much?____
Do you use tobacco products?□ YES □ NO How often/amount:____
Have you used tobacco products in the past? □ YES □ NO If yes, when did you stop? ____________________________

FAMILY HISTORY
Please list pertinent family medical history (i.e. cancers / anemia / bleeding (or clotting disorders/stroke):
Mother:_____________________________________ Father:____
Children:___________________________________ Siblings:____

SPIRITUAL
Religious Preference:____
If you require surgical intervention, would you appreciate your surgeon praying with you before the operation? □ YES □ NO

REVIEW OF SYSTEMS

GENERAL
- ☐ Fever
- ☐ Chills
- ☐ Weight Loss________________(amount/time duration)
- ☐ Weight Gain__________________ (amount/time duration)
- ☐ Fatigue / Feeling Poorly

EYES
- ☐ Vision Problems
- ☐ Eye Pain

ENT
- ☐ Nasal Congestion
- ☐ Hoarseness
- ☐ Swallowing Problems (Food Stuck in Throat)

CARDIAC
- ☐ Irregular Heart Rate / Palpitations
- ☐ Chest Pain
- ☐ Blood Clots
- ☐ Pain in Legs with Walking
- ☐ Swelling in Legs

PULMONARY
- ☐ Shortness of Breath (if so, when?_____________________)
- ☐ Cough
- ☐ Wheezing
- ☐ Trouble Breathing when Laying Flat
- ☐ Home Oxygen
- ☐ CPAP
- ☐ Sleep Apnea

GASTROINTESTINAL
- ☐ Abdominal Pain (if yes, location ____________________)
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Heartburn
- ☐ Black / Tarry Stools
- ☐ Blood in Your Stool

GENITOURINARY
- ☐ Pelvic Pain (if yes, when?____________)
- ☐ Burning with Urination
- ☐ Incontinence

For Men
- ☐ Erectile Dysfuncion

For Women
- ☐ Abnormal Vaginal Bleeding
- ☐ Pregnant
- ☐ Excessive Pain with Periods

HEMATOLOGIC / LYMPHATIC
- ☐ Enlarged Lymph Nodes
- ☐ Painful Lymph Nodes
- ☐ Easy Bleeding / Bruising

MUSCULOSKELETAL
- ☐ Joint Pain
- ☐ Muscle Aches
- ☐ Extremity Weakness
- ☐ Difficulty Walking

NEUROLOGICAL
- ☐ Confusion
- ☐ Seizures
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting Spells
- ☐ Tremor
- ☐ Difficulty Speaking

SKIN / BREAST
- ☐ Skin Lesions / Wounds
- ☐ Change in Mole
- ☐ Breast Pain
- ☐ Breast Lump

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Suicidal Thoughts
- ☐ Hallucinations
- ☐ Emotional Problems

ENDOCRINE
- ☐ Hot Flashes
- ☐ Voice Changes
- ☐ Excessive Sweating
- ☐ Increased Thirst
- ☐ Increased Urination

UNITY HEALTHCARE, LLC
DISCLOSURE AND RELEASE AUTHORIZATION FORM

CONSENT TO TREAT: I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as my physician, in his/her professional judgment, deems necessary or beneficial. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

_______________ **Intl**

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INSURANCE BENEFITS:
I authorize Unity and my physician to release information from my medical records to my insurance carrier(s), governmental agency, or my employer in the case of work-related injuries, for the purpose of processing claims for medical/workers compensation benefits and state on such claims that my signature is on file. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

_______________ **Intl**

FINANCIAL AGREEMENT: I understand all accounts are the full responsibility of the patient and/or the patient's responsible party guarantor. My physician will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account of future outstanding accounts. I agree that reasonable attorney fees shall be interpreted as 40% of any balance due at the time the account is sent to an attorney or collection agency for collection, or $200.00, whichever is greater.

_______________ **Intl**

MEDICARE CERTIFICATION: I certify that the information given by me, or by Unity on my behalf, in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my treating physician to release information from my medical record to the Social Security Administration and/or Medicare program or its intermediaries or carriers, or the Professional Standards Review Organizations for the purpose of processing of claims for medical benefits and state on such claims that my signature is on file. I request that payment of such authorized benefits be made directly to my treating physician on my behalf.

_______________ **Intl**

TELEPHONE CONTACTS: I authorize Unity Healthcare, LLC and its affiliates and agents to contact me at the phone numbers I have provided (whether such is my cell phone or land line), including providing me with automated appointment reminders and other automated calls related to the services provided to me.

_______________ **Intl**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I have received the Practice's Notice of Privacy Practices and understand that my protected health information maybe used by the Practice as described in the notice.

_______________ **Intl**

Patient Name/Signature: ____ Date:____________
Parent/Guardian Signature: ______________________________________ Date:____________

UNITY HEALTHCARE, LLC
HIPAA AUTHORIZATION DISCLOSURES TO FAMILY AND/OR FRIENDS

Patient Name:______________________________________ **Patient DOB:**_________________

By signing below, I hereby authorize the following health information to be used and disclosed as described in this Authorization ("Protected Health Information").

Unity may disclose my Protected Health Information, as indicated, to the following persons or class of persons:

Name	Relationship	ALL Information	Health/ Clinical Only	Financial Only	Specific Service Dates	Specific Health Issue

I understand that the purpose of the use or disclosure is: at my request, to enable them to be aware of and participate in my care and treatment provided by Unity.

__________ **Intl**

I understand that Unity will not condition treatment, payment, and enrollment in a health plan or eligibility for benefits on the provision of this Authorization to Unity.

__________ **Intl**

I understand that the information to be disclosed may contain information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, hepatitis, tuberculosis, and treatment for alcohol and drug abuse.

☐ No, I do not authorize this type of disclosure.

__________ **Intl**

This Authorization shall expire: one (1) year from the date signed below.

__________ **Intl**

I understand that I have the right to revoke this Authorization by contacting Unity, if the revocation is in writing, except to the extent that Unity has taken action in reliance upon this Authorization.

__________ **Intl**

I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to re-disclosure by the recipient, and the privacy of my Protected Health Information may no longer be protected by the law.

__________ **Intl**

I understand that the use or disclosure of my Protected Health Information by Unity will not result in direct or indirect remuneration to Unity from a third party.

__________ **Intl**

By signing this Authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms herein.

Patient Signature:____Date:___________________