

MICHAEL P. ALBERT

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PIONEER VALLEY SURGICAL ASSOCIATES, P.C.

2 Medical Center Drive, Suite 404 ♦ Springfield, MA 01107 ♦ TEL: (413) 736-3163

(PLEASE PRINT)

DATE:	REFERRED TO PVSA BY:	PRIMARY CARE PHYSICIAN:
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DO YOU HAVE ANY LATEX ALLERGIES? YES NO

PATIENT INFORMATION

DATE OF BIRTH:	AGE:	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SOCIAL SECURITY #:
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PREFIX	PATIENT'S NAME:	MARITAL STATUS
<input type="checkbox"/> MR <input type="checkbox"/> MRS <input type="checkbox"/> MS <input type="checkbox"/> MISS	LAST FIRST MIDDLE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MAR <input type="checkbox"/> DIV <input type="checkbox"/> SEP <input type="checkbox"/> WID

MAIDEN NAME:	IS THIS YOUR LEGAL NAME: <input type="checkbox"/> YES <input type="checkbox"/> NO	IF NOT, WHAT IS YOUR LEGAL NAME:
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HOME ADDRESS:	MAILING ADDRESS (IF DIFFERENT):
CITY: STATE: ZIP:	CITY: STATE: ZIP:
EMAIL ADDRESS:	

HOME PHONE:	CELLULAR PHONE:	WORK PHONE:
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EMPLOYMENT

OCCUPATION:	EMPLOYER:	EMPLOYER ADDRESS:
		CITY: STATE: ZIP:

IN CASE OF EMERGENCY

EMERGENCY CONTACT NAME: _____

RELATIONSHIP TO PATIENT: _____

HOME PHONE: () _____ **OTHER:** () _____

INSURANCE

PRIMARY INSURANCE: _____

SECONDARY INS: _____

INSURANCE ID #: _____

INSURANCE ID #: _____

GROUP #: _____

GROUP #: _____

SUBSCRIBER NAME: _____

SUBSCRIBER NAME: _____

SUBSCRIBER DATE OF BIRTH: ___/___/___

SUBSCRIBER DATE OF BIRTH: ___/___/___

◀◀◀ PLEASE COMPLETE REVERSE SIDE ▶▶▶

INSURANCE (CONTINUED)

ADDITIONAL INSURANCE: _____

INSURANCE ID #: _____ GROUP #: _____

SUBSCRIBER NAME: _____

SUBSCRIBER DATE OF BIRTH: ____/____/____

ADDITIONAL INSURANCE: _____

INSURANCE ID #: _____ GROUP #: _____

SUBSCRIBER NAME: _____

SUBSCRIBER DATE OF BIRTH: ____/____/____

PERSON RESPONSIBLE FOR PAYMENT (OTHER THAN PATIENT) REGARDLESS OF INSURANCE

PERSON RESPONSIBLE FOR BILL: _____

ADDRESS: _____
(IF DIFFERENT FROM ABOVE)

HOME PHONE: () _____ OTHER: () _____

The above information is true to the best of my knowledge. I authorize Pioneer Valley Surgical Associates, P.C. physicians and personnel to administer, care, treat and/or perform any procedure that is considered necessary and advisable by the physicians of Pioneer Valley Surgical Associates, P.C.

I authorize Pioneer Valley Surgical Associates, P.C. to forward copies of my medical records to my primary and/or referring physician for the purpose of continuing treatment.

I authorize Pioneer Valley Surgical Associates, P.C. to request copies of my Explanation of Benefits (EOB), and billing for physician, hospital and/or other service providers in order to provide information for the purpose of coordination of benefits, education and health systems research.

I authorize any physician, health care practitioner, hospital or medical care facility to provide all information on the above patient's medical history to Pioneer Valley Surgical Associates, P.C.

I authorize Pioneer Valley Surgical Associates to send me practice information via e-mail. This does not include personal medical information.

I, the undersigned, hereby authorize payment directly to Pioneer Valley Surgical Associates, P.C. of medical/surgical benefits, if any, otherwise payable to me under the terms of my health insurance policy. I fully understand that I am primarily and financially responsible for fees incurred by the above patient. I further understand that payment is not contingent on any settlement, judgment or verdict by which the above patient may eventually recover said medical/surgical fees.

I have read this consent form carefully, and understand its contents.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

DATE

REVIEW OF SYSTEMS

DATE: _____

NAME: _____

DOB: _____

ALLERGIES TO FOOD/MEDICATIONS:

Have you had any of the following symptoms or difficulties in the past year?

PLEASE CIRCLE EITHER YES OR NO TO EACH QUESTION

CARDIOVASCULAR:

YES NO Chest Pain
YES NO Recent Heart Problems

CONSTITUTIONAL:

YES NO Fever
YES NO Weight Loss
YES NO Change in Appetite

ENT:

YES NO Hearing Problems
YES NO Nosebleeds
YES NO Sinus Infections
YES NO Recent Sore Throat

EYES:

YES NO Visual Problems or Changes

GASTROINTESTINAL:

YES NO Nausea, Vomiting
YES NO Change in Bowel Habits
YES NO Blood in Stools
YES NO Abdominal Pain

GENITOURINARY:

YES NO Pain with Urination
YES NO Blood in Urine
YES NO Increased Frequency of Urination

GYN (FEMALES ONLY):

YES NO Change in Menstrual Cycle

HEMATOLOGIC:

YES NO Bleeding Problems
Lymphatic - Lumps in Neck, Groin

MUSCULOSKELETAL:

YES NO Aches, Weakness, Swelling

RESPIRATORY:

YES NO Shortness of Breath
YES NO Coughing
YES NO Recent Pneumonia

SKIN:

YES NO Itching, Rashes, New Moles

SOCIAL HISTORY:

Do you smoke? YES NO

Consumption of alcohol?

DAILY WEEKLY SELDOM NEVER

OCCUPATION: _____

FOR OFFICE USE ONLY

HT: _____

WT: _____

BP: _____

PIONEER VALLEY SURGICAL

A S S O C I A T E S , P . C .

2 Medical Center Drive, Suite 404
Springfield, Massachusetts 01107

TEL: (413) 736-3163
FAX: (413) 733-0206

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of Pioneer Valley Surgical Associates, P.C. Notice of Privacy Practices.

SIGNATURE: _____ **DATE:** _____

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices, but was unable to do so as documented below:

DATE: _____ **INITIALS:** _____ **REASONS:** _____

AUTHORIZATION OF INFORMATION DISCLOSURE

- ❖ Please list the family members or persons, if any, whom we may inform about your general medical condition, diagnosis including treatment, healthcare operations and payment.

- ❖ Please list the telephone number where you can receive calls about your appointments, test results or other healthcare information.

HOME TEL: _____ **OTHER #'S:** _____

*****Cell phones are not a secure and private line*****

- ❖ Can confidential messages (appointment reminders and changes, etc.) be left on your telephone answering machine?

YES _____ NO _____

- ❖ Please list the family members or persons, if any, whom may pick up prescriptions, lab slips or other healthcare information.

- ❖ Please indicate if you want all correspondence sent in a sealed envelope marked "CONFIDENTIAL"

YES _____ NO _____

PATIENT'S NAME: _____

SIGNATURE: _____

DATE: _____