PIONEER VALLEY SURGICAL ASSOCIATES, P.C.

2 Medical Center Drive, Suite 404 ◆ Springfield, MA 01107
TEL: (413) 736-3163 ◆ **FAX:** (413) 733-0206

PATIENT REGISTRATION

☐ MICHAEL P. ALBERT ☐ ALBERT I. ALEXANDER
☐ MATTHEW R. BRACKMAN ☐ BURRITT L. HAAG III

(PLEASE PRINT)

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

PATIENT INFORMATION

DATE OF BIRTH:	**AGE:**	**SEX:** ☐ MALE ☐ FEMALE	**SOCIAL SECURITY #:**

PREFIX	**PATIENT'S NAME:**			**MARITAL STATUS**
☐ MR ☐ MRS ☐ MS ☐ MISS	LAST	FIRST	MIDDLE	☐ SINGLE ☐ MAR ☐ DIV ☐ SEP ☐ WID

MAIDEN NAME:	**IS THIS YOUR LEGAL NAME:** ☐ YES ☐ NO	**IF NOT, WHAT IS YOUR LEGAL NAME:**

HOME ADDRESS:	**MAILING ADDRESS (IF DIFFERENT):**
CITY: **STATE:** **ZIP:**	**CITY:** **STATE:** **ZIP:**
EMAIL ADDRESS:	

HOME PHONE:	**CELLULAR PHONE:**	**WORK PHONE:**

EMPLOYMENT

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

IN CASE OF EMERGENCY

EMERGENCY CONTACT NAME: _____

RELATIONSHIP TO PATIENT: _____

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

INSURANCE

PRIMARY INSURANCE:_____
INSURANCE ID #:_____
GROUP #:_____
SUBSCRIBER NAME:_____
SUBSCRIBER DATE OF BIRTH:_____/_____/_____

SECONDARY INS:_____
INSURANCE ID #:_____
GROUP #:_____
SUBSCRIBER NAME:_____
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**

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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:** _____

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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:** _____

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HISTORY & PHYSICAL

DATE: _____/_____/_____ **CHART #** _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____/_____/_____

Health Information Technology for Economic and Clinical Information Act (HITECH) requires us to ask the following information in order to be compliant with the federal guidelines for electronic medical records. Thank you for your cooperation.

Please complete the following by checking one that most applies:

RACE:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Refuse to Report/Unreported

ETHNICITY: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Refuse to Report/Unreported

LANGUAGE:
- ☐ English
- ☐ French
- ☐ German
- ☐ Japanese
- ☐ Mandarin
- ☐ Russian
- ☐ Spanish

Primary Care Physician _____ Referral Physician _____

Reason for Visit _____

Date of First Symptoms: _____/_____/_____

PAST MEDICAL HISTORY:
Please indicate if you have had any of the following (check all that apply)

☐ Anemia	☐ Heart Murmur	☐ Purging
☐ Binge Eating	☐ Heartburn	☐ Rashes in Skin Folds
☐ Blood Clots	☐ Hiatal Hernia	☐ Sleep Apnea
☐ Depression	☐ High Blood Pressure	☐ Stomach Ulcer
☐ Diabetes	☐ High Cholesterol	☐ Surgery for Obesity
☐ Esophageal Reflux (GERD)	☐ Laxative Used to Lose Weight	☐ Urinary Incontinence
☐ Heart Attack	☐ Leg Ulcers	

PAST SURGICAL HISTORY & DATE:

_____ _____

_____ _____

_____ _____

<<PLEASE COMPLETE REVERSE SIDE>>

REVIEW OF SYSTEMS: (Please respond Yes or No to all areas)

YES	NO		YES	NO		YES	NO	
☐	☐	Weight Loss	☐	☐	Chest Pain	☐	☐	Increased Urination
☐	☐	Change in Appetite	☐	☐	Recent Heart Problems	☐	☐	Blood in Urine
☐	☐	Fever	☐	☐	Coughing	☐	☐	Pain w/Urination
☐	☐	Nose Bleeds	☐	☐	Recent Pneumonia	☐	☐	Change in Menstrual Cycle
☐	☐	Visual Problems	☐	☐	Shortness of Breath	☐	☐	Aches/Weakness/Swelling
☐	☐	Hearing Problems	☐	☐	Change in Stools	☐	☐	Itching/Rashes
☐	☐	Recent Sore Throat	☐	☐	Nausea, Vomiting	☐	☐	New Moles
☐	☐	Sinus Infections	☐	☐	Blood in Stools	☐	☐	Lumps in Neck/Groin
☐	☐	Pacemaker	☐	☐	Abdominal Pain	☐	☐	Bleeding Problems

MEDICATIONS (Please include over the counter medications and vitamins/herbs):

PRESCRIPTION NAME	DOSE	A.M./P.M.	PRESCRIPTION NAME	DOSE	A.M./P.M

SLEEP APNEA PATIENTS:
If you have been diagnosed with sleep apnea, please write CPAP if you are using this treatment.

ALLERGIES: ☐ Latex ☐ Food _____ Reaction _____

☐ Drugs _____ Reaction _____

SOCIAL HISTORY:
Do you drink alcohol? ☐ Yes ☐ No If yes, how often? ☐ Daily ☐ Weekly ☐ Seldom ☐ Never

Tobacco Use: ☐ Yes ☐ No If yes, how long? _____ When did you quit? _____

Occupation: _____ Work Place: _____

FAMILY HISTORY:
Do any of the following diseases run in your family (parents, sisters, brothers). Please check all that apply.

YES	MEDICAL CONDITION	FAMILY MEMBER(S) AFFECTED	IF DECEASED, AGE & CONDITION
☐	Breast Cancer		
☐	Diabetes		
☐	Early heart attacks before the age of 60		
☐	Obesity		
☐	Thyroid Problems		
☐	Other:		

FOR OFFICE USE ONLY: Height: _____ Weight: _____

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BARIATRIC HISTORY

DATE: _____/_____/_____

PATIENT NAME: _____ **DATE OF BIRTH:** _____/_____/_____

Current Weight _____ Height _____ Weight at End of High School _____

Lowest Adult Weight _____ Highest Adult Weight _____

1. When did you begin to have problems with your weight?

   _____

2. Can you relate your weight gain to any life time events?

   ☐ Pregnancy ☐ Death of Friend/Family ☐ Quitting Smoking ☐ Life Stress ☐ Divorce

   Other _____

3. **PLEASE CHECK ALL TYPES OF WEIGHT LOSS PROGRAMS YOU HAVE TRIED**

TYPE OF DIET	WEIGHT LOSS	WEIGHT GAIN	DATES/DURATION
☐ Atkin's			
☐ Curves			
☐ Healthy Solutions			
☐ Jenny Craig			
☐ Medi-Fast			
☐ New Direction			
☐ Nutri System			
☐ Opti-Fast			
☐ Over Eaters Anonymous			
☐ Richard Simons			
☐ Shape Up America			
☐ Slim Fast			
☐ The Solution			
☐ The Zone			
☐ Weight Watchers			
☐ Other:			

<<PLEASE COMPLETE REVERSE SIDE>>

4. Have you used medication prescribed by a physician or over the counter?
   Please check all that apply

NAME OF MEDICATION	WEIGHT LOSS	DATES/DURATION
☐ Amphetamines		
☐ Anti-depressants used for weight loss		
☐ Dexatrim, Trim Spa or other like these		
☐ Meridia		
☐ Phen-Fen ***see below		
☐ Redux *** see below		
☐ Xenical		
☐ Other		

*** If you were on Phen-Fen or Redux, have you had an EKG done to check your heart valves?
☐ YES ☐ NO

PERSONAL EXPECTATIONS/GOALS

1. What are your expectations of the weight loss procedure the first few weeks after surgery?

   _____

2. What are your expectations one year after surgery?

   _____

3. Are you willing to take the recommended daily vitamin and mineral supplements for life and follow the nutrition recommendations with a focus on healthy eating? ☐ YES ☐ NO

4. Are you willing to engage in regular exercise? ☐ YES ☐ NO

5. Are you willing to come to Pioneer Valley Surgical Associates for regular follow-up appointments for at least two years after surgery? ☐ YES ☐ NO

6. Are you willing to come to monthly support groups meetings before and after surgery?
   ☐ YES ☐ NO

7. Do you know someone who has had weight loss surgery?
   ☐ YES ☐ NO Relationship: _____

8. In reference to question 7 were their expectations met after the surgery? ☐ YES ☐ NO

9. May we communicate with you by email? ☐ YES ☐ NO
   EMAIL ADDRESS: _____@_____

_____ Date _____/_____/_____
SIGNATURE