College Station Surgical Associates
Henry E. Bohne, MD, FACS • John W. Williams, MD, FACS • David C. Gochnour II, MD

Health History

Date:_____

(Confidential)

Name:_____ Birthdate:_____

What is the reason for your visit?_____

_____

Referring MD: _____

PCP: _____

Symptoms: Check ☑ symptoms you currently have **OR** have had within the past **YEAR.**

General:

- ☐ Fever
- ☐ Chills
- ☐ Weight loss or gain
- ☐ Headache

ENT:

- ☐ Difficulty Swallowing
- ☐ Persistent Cough
- ☐ Change in Hearing
- ☐ Change in Vision
- ☐ Sinus Problems

Cardiovascular:

- ☐ Chest Pain
- ☐ Rapid Heart Beat
- ☐ Swelling of ankles
- ☐ Calf Pain
- ☐ Diarrhea

Gastrointestinal:

- ☐ Hemorrhoids
- ☐ Reflux/GERD
- ☐ Nausea/Vomiting
- ☐ Rectal Bleeding
- ☐ Change in Bowel Habits
- ☐ Poor Appetite
- ☐ Bloating
- ☐ Constipation

Respiratory

- ☐ Shortness of Breath
- ☐ Difficulty breathing

Genito-Urinary:

- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of bladder control
- ☐ Painful or Burning Urination

Muscle/Joint/Bone:

- ☐ Back Pain
- ☐ Muscle Pain
- ☐ Joint Pain

Skin

- ☐ Bruise Easily
- ☐ Abnormal Moles, Rashes or Lesions

Neurologic

- ☐ Numbness
- ☐ Weakness
- ☐ Tingling, Pricking, or Burning Sensation

Medications:

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

✱Allergies:

_____
_____
_____
_____

College Station Surgical Associates

Henry E. Bohne, MD, FACS • John W. Williams, MD, FACS • David C. Gochnour II, MD

Social History:

Marital Status: ❑ Single ❑Married ❑Divorced ❑Widowed ❑Separated ❑Partner

Do you use **Tobacco Products**:❑ Smoke ❑ Smokeless **Alcohol**:❑ Yes ❑ No

Frequency:_____ Type & Frequency:_____

Illicit Drug Use: ❑ Yes ❑No Type & Frequency:_____

Caffeine Products: ❑ Yes ❑ No Type & Frequency:_____

Past Medical History: *List all medical conditions managed by a Physician:*

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Surgical History: *List all surgical Procedures:*

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Family History:

Father - Age:_____ Medical conditions: _____

If deceased, Age and Cause:_____

Mother - Age:_____ Medical Conditions:_____

If deceased, Age and Cause:_____

Siblings - Age:_____ Medical Conditions:_____

If deceased, Age and Cause:_____

Other - Age: _____ Medical Conditions:_____

If deceased, Age and Cause:_____

College Station Surgical Associates

Henry E. Bohne, MD, FACS • John W. Williams, MD, FACS • David C. Gochnour II, MD

PLEASE FILL IN ALL QUESTIONS AND PRINT CLEARLY *Today's Date:* _____

Patient SS #_____ Date of Birth: _____ Cell Phone: _____

Patient Name: _____ Home Phone: _____ Work Phone: _____

Patient Address: _____ City: _____ State: _____ Zip: _____

If Minor – Please complete

Parent/Guardian: _____ Contact Phone: _____

Relationship to Patient: _____ Email:_____

Address: _____ City: _____ State: _____ Zip: _____

___Male ____Female ____ Single _____ Married _____Divorced ___ Widowed

Employer Information:

Patient Employer: _____ Department: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Employer Phone Number: _____ Ext: _____

Spouse Information:

Spouse Name: _____ Spouse Contact Phone: _____

Spouse SS #_____ Date of Birth: _____

Employer Name: _____ Work Phone: _____ Cell Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Person to Contact in Case of Emergency:

Name: _____ Home Phone: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Insurance Coverage: _____ Yes _____ No _____ Cash _____ Medicaid ____ Medicare

Is This Workers Compensation? / Accident Related? _____ Yes _____ No

Date of Accident: _____ Auto _____ Work _____ Other

PRIMARY COVERAGE

Insured Party: _____ Self _____ Spouse ____ Other/ Relationship_____

Insured Name: _____ Insured SS#:_____ Date of Birth: _____

Insurance Name: _____ Policy#:_____ Group#:_____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Insurance Phone Number: _____ Relationship to insured: _____

SECONDARY COVERAGE

Insured Party: _____ Self _____ Spouse ____ Other/ Relationship_____

Insured Name: _____ Insured SS#:_____ Date of Birth: _____

Insurance Name: _____ Policy#:_____ Group#:_____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Insurance Phone Number: _____ Relationship to insured: _____

College Station Surgical Associates
Henry E. Bohne, MD, FACS • John W. Williams, MD, FACS • David C. Gochnour II, MD

Patient Information Form

ALL PROFESSIONAL FEES ARE DUE AT THE TIME OF SERVICE, UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE.

Financial Agreement

1. Services are rendered to the patient, not the insurance company. As a courtesy, our office will file your insurance if proper information is received.
    A. You are responsible for co-pays, deductibles, non-covered services, co-insurances and items considered "not medically necessary" by your insurance company.
    B. For unpaid claims over 45 days, it is your responsibility to follow up with your insurance and the balance due is considered due and payable.
2. It is you're responsiblity to notify our front desk staff of any insurance or address changes.
3. You will be responsible for any charges that occur if we are not notified.
4. Any debt incurred to collect a debt will be at the expense of the patient/responsible party.

Patient Authorization

I authorize College Station Surgical Associates to submit insurance claims using my signature on file below. I authorize the release of any medical information necessary in order to process this assignment on the claim. I authorize payment of medical benefits to be paid directly to College Station Surgical Associates for services describe on the claim form.

_____ _____
Patient Signature (or authorizes representative) Date

I authorize College Station Surgical Associates to release any medical or billing information necessary, for treatment, payment or healthcare operations to the following family and or friends: (listed names and relationship)

_____
_____
_____

_____ _____
Patient Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ (print patient name), hereby acknowledge that I have received and reviewed the Privacy Notice of **College Station Surgical Associates**.

Signature: _____ Date: _____

Print Name: _____
Relationship (if not patient) _____

College Station Surgical Associates
Henry E. Bohne, MD, FACS • John W. Williams, MD, FACS • David C. Gochnour II, MD

Patient Consent for E-Prescribing (Electronic Prescribing)

I have been made aware and understand this office may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my provider and my pharmacy. I have been informed and understand that my provider using the electronic prescribing system will be able to see information about medications I am already taking; including those prescribed by other providers. I give consent to my providers to see the protected health information.

I choose the pharmacy below as my primary pharmacy:

Pharmacy Name:_____

Address:_____ City_____, TX. Zip_____

_____ **Preferred LAB**:_____
Patient Name

_____ _____
Patient Signature or Legal Representative Signature Date

Request for Confidential Communication of Protected Health Information

I request communication of my protected health information by the following means and at the following locations. I understand this request applies only to communication from this office to the patient, and communication that would be sent to the name of the insured of an insurance policy that covers the patient as a dependent of the names insured.

Please indicate the methods and/or locations by or at which we may contact you.

Telephone Number:_____

Mailing address:_____

Email Address:_____

Note: This request will remain in effect until you notify us of a change.

Printed Name: _____ Date:_____

Signature:_____

Relationship (if not patient):_____

Patient's Date of Birth:_____ Patient's SS#:_____