METROLINA SURGICAL SPECIALISTS, PLLC

*Vascular Surgery * General Surgery * Surgical Endoscopy * Laparoscopic Surgery*

Obinna N. Eruchalu, MD, FACS, FICS, RPVI

Welcome

Date _____

Patient Name _____ Sex _____

Date of Birth _____ SSN _____

Address _____

City, State, Zip _____

Home Phone _____ Cell Phone _____

Drivers License Number/State _____ [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Guarantor if Minor _____ Relationship _____

Guarantor Date of Birth _____ Guarantor SSN _____

Patient Employer _____

Employer Address _____

Emergency Contact _____ Relationship _____

Address _____ Phone _____

Primary Insurance Carrier _____

Insured's Name _____

Relationship to Patient _____ Insured's Date of Birth _____

Policy Number _____ Group Number/Name _____

Secondary Insurance Carrier _____

Insured's Name _____

Relationship to Patient _____ Insured's Date of Birth _____

Policy Number _____ Group Number/Name _____

Payment is required at time of visit. An insurance claim will be filed as a courtesy.

The information on this form is true and correct to the best of my knowledge. I hereby authorize the release of medical information to my insurance company. I hereby authorize payment of insurance benefits to Metrolina Surgical Specialists. I do hereby agree to pay all medical charges incurred by the above listed patient. I understand that these charges are my responsibility regardless of insurance coverage. I further agree in the event of non payment, to bear the cost of collections, and/or court cost and reasonable legal fess should this be required.

Signature _____ Date _____

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Medical History Form

Please answer the following questions to the best of your knowledge:

NAME:_____ DATE:_____

DATE OF BIRTH:_____

MEDICAL HISTORY

Do you have any of the following?

_____Hypertension	_____Lung Disease	_____Seizures	_____HIV/AIDS
_____High Cholesterol	_____Stroke	_____Cancer	_____Ulcers
_____Heart Disease	_____Reflux	_____Diabetes	_____Other
_____Liver Disease			

Recent illnesses or hospitalizations and conditions:_____

_____

Give year of surgeries.

_____No Surgeries	_____Breast Biopsy	_____Hernia Repair	_____Mastectomy
_____Gallbladder	_____Hysterectomy		_____Other – List

Other Surgeries:_____

_____

SOCIAL HABITS

USE OF ALCOHOL	_____Never	_____Occasionally	_____Daily
USE OF CAFFEINE	_____Soft Drinks	_____Coffee/Tea	_____How much per day
USE OF TOBACCO	_____Smoke	_____Chew	_____How Much?
	_____Previous, but Quit		_____Date Quit

FAMILY HISTORY

Does anyone in your family have and of the following conditions? If so, give relationship

_____Hypertension	_____Diabetes
_____Heart Disease	_____Bleeding Disorder
_____Stroke	_____Seizure Disorder
_____Cancer	_____Obesity
_____Peripheral Vascular Disease	_____Other

PHYSICIAN SIGNATURE_____ DATE:_____

1928 Randolph Road, Suite 312, Charlotte, NC 28207
Phone (704) 375-0404
Fax (704) 375-0705

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Fax (704) 292-7880

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REVIEW OF SYSTEMS

NAME:_____ DATE OF BIRTH:_____

Are you experiencing any of the following?

GENERAL			**MUSCULOSKELTAL**	
Fever	YES / NO		Joint Pain/Swelling	YES / NO
Fatigue	YES / NO		Muscle/joint Weakness	YES / NO
Recent Weight Change	YES / NO		Back Pain	YES / NO
Unable to Sleep	YES / NO		Cold Extremities	YES / NO
Stress	YES / NO		Numbness/Tingling – Legs	YES / NO
			Numbness/Tingling – Arms	YES / NO
EYES EARS NOSE & THROAT				
Wear Glasses/Contacts	YES / NO		**BREASTS**	
Eye/vision Problems	YES / NO		Breast Pain	YES / NO
Hearing Loss/Ringing	YES / NO		Breast Lump	YES / NO
Ear Aches	YES / NO		Nipple Discharge	YES / NO
Nose Bleeds	YES / NO		History of Breast Cancer	YES / NO
Sinus Problems	YES / NO			
Frequent Colds	YES / NO		**NEURO/PSYCHOLOGICAL**	
Dental Problems	YES / NO		Frequent headaches	YES / NO
Sore Throat/Hoarseness	YES / NO		Light Headed/Dizzy	YES / NO
Swollen Glands	YES / NO		Tremors	YES / NO
			Paralysis/Stroke	YES / NO
HEART AND LUNGS			Memory Loss/Confusion	YES / NO
Chest Pain/Heart Attack	YES / NO		Depression/Anxiety	YES / NO
Irregular/Fast Heartbeat	YES / NO			
Heart Failure	YES / NO		**ENDOCRINE**	
Angina	YES / NO		Glandular Problems	YES / NO
Murmur	YES / NO		Hormonal Problems	YES / NO
Shortness of Breath	YES / NO		Excessive Thirst	YES / NO
Cough	YES / NO		Excessive Urination	YES / NO
Spitting Up Blood	YES / NO		Intolerance Cold/Hot	YES / NO
Asthma/Wheezing	YES / NO			
			SKIN	
GASTROINTESTINAL			Rash/Itching	YES / NO
Loss of Appetite	YES / NO		Bleeding/Bruising	YES / NO
Nausea/Vomiting	YES / NO		Change in Skin/Hair	YES / NO
Diarrhea	YES / NO			
Constipation	YES / NO		**BLEEDING DISORDERS**	
Change in Bowel Habits	YES / NO		Slow to Heal	YES / NO
			Anemia	YES / NO

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REVIEW OF SYSTEMS—continued

NAME:_____ DATE OF BIRTH:_____

Are you experiencing any of the following?

GENITOURINARY			**WOMEN ONLY**	
Frequent Urination	YES / NO		Painful Periods	YES / NO
Painful/Burning Urination	YES / NO		Last Menstrual Period	_____
Bladder Control Problems	YES / NO		Last Pap Smear	_____
Kidney Stones	YES / NO		Number of Pregnancies	_____
Change in Urine Force	YES / NO		Did you Breast Feed	YES / NO
Venereal Disease	YES / NO		Age Started Period	_____
MEN ONLY			**PERIPHERAL VASCULAR**	
Testicular Pain	YES / NO		Leg Pain When Walking	YES / NO
Prostate Problems	YES / NO		Leg Pain Without Activity	YES / NO
			Discoloration of Toes/Feet	YES / NO
CEREBROVASCULAR			Sores/Ulcers on Feet/Ankles	YES / NO
Stroke	YES / NO		Pain in Toes When Cold	YES / NO
Temporary Numbness/Weakness	YES / NO		Bypass Surgery on Legs	YES / NO
Slurred or Difficult Speech	YES / NO		Right or Left	_____
Dizziness	YES / NO		Amputation Toes/Foot/Leg	YES / NO
Blindness in One or Both Eyes	YES / NO		Specify	_____
Double Vision	YES / NO		Pain in Arms With Activity	YES / NO
Blackouts	YES / NO		Pain in Arms Without Activity	YES / NO
Memory Loss	YES / NO		Sores/Ulcers on Fingers	YES / NO
			Discoloration of Fingers	YES / NO
VENOUS CIRCULATION			Pain in Fingers When Cold	YES / NO
Blood Clots	YES / NO		Bypass Surgery on Arms	YES / NO
Swelling of Legs	YES / NO		Right or Left	_____
Pain in Legs	YES / NO		Amputation Fingers/Hand/Arm	YES / NO
Redness of Leg or Foot	YES / NO		Specify	_____
Sores on Ankles	YES / NO		Shunt in Arm for Dialysis	YES / NO
Varicose Veins	YES / NO		Right or Left	_____
Vein Stripping/Injections	YES / NO			
Right or Left	_____			
Phlebitis	YES / NO			

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Medication Log

Please List All Medication You're Currently Taking

NAME_____ PATIENT NUMBER_____

BIRTHDATE_____ ALLERGIES_____

PHARMACY_____ PHARMACY PHONE NUMBER_____

MEDICATION	DIRECTIONS	REFILLS

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Practice Policies

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following policies. If you have any questions about the policy, please discuss them with our office manager or billing supervisor. We are dedicated to providing the best possible care and services to you and regard your understanding of our policies as an essential element of your care and treatment.

Financial:
We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will require you to pay the authorized co-payment or deductible at the time of service. It is the policy of our office to collect the co-payment when you arrive for your appointment.

In the event your insurer or health plan does not pay, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

Unless other arrangements have been made in advance we expect full payment at the time of service. For your convenience we will accept VISA, MasterCard, American Express and Discover Card.

Minor Patients:
For all services rendered to minor patients, we will look to the parent(s)/guardian(s) of the patient, authorizing treatment and the parent or guardian with custody for payment.

Missed Appointments:
In order to provide the best possible service and availability to all our patients it is our policy to charge our office visit fee for any appointments not cancelled at least one day prior to the appointment. Please call us as early as possible if you know you will need to reschedule your appointment.

Medical Records:
Metrolina Surgical Specialists makes every effort to protect private health information. In compliance with state and federal regulations, medical records are maintained on all patients up to seven years after the last date-of-service. At that time, medical records are destroyed per HIPAA guidelines. You may request a copy of your records up to that time.

I have read and understand the policies of the practice and I agree to be bound by its terms. I agree in the event of financial default to bear the cost of collections and/or court cost including reasonable attorney fees and interest at a rate of 8% from date of service. I understand that I may request a copy of my medical record and that there may be a fee for copying. I also understand and agree that such terms may be amended from time to time by the practice.

_____	_____
Name of Patient	Date
_____	_____
Signature of Patient or Responsible Party	Witness

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Records Release Authority

TO: _____

_____

_____

_____

I, _____ hereby request that you release a report of my diagnosis, treatment, prognosis, and recommendations, as well as other date pertinent to your treatment of me to:

_____

_____

_____

_____

_____ _____
Patient's Signature | Witness

_____ _____
Patient's Date of Birth | Date

_____ _____
Patient's Address | City, State, Zip Code

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