MAT-SU SURGICAL ASSOCIATES

Patient Interview Form

First Name_____ Last Name_____ Date of Birth _____ Age _____

Past or Present Medical Conditions				
☐ None				
☐ Anemia	☐ Barrett's Esophagus	☐ Hypothyroidism	☐ Breast Cancer	☐ Arthritis
☐ Atrial Fibrillation	☐ Reflux Disease (GERD)	☐ Hyperthyroidism	☐ Lung Cancer	☐ Gout
☐ Congestive Heart Failure	☐ Peptic Ulcer Disease	☐ Thyroid Cancer	☐ Pre-Diabetes	☐ Parkinson's Disease
☐ Coronary Artery Disease	☐ Bowel Obstruction	☐ Parathyroid Disease	☐ Diabetes- Type 1	☐ Seizure Disorder
☐ Heart Attack	☐ Diverticulitis	☐ Asthma	☐ Diabetes- Type 2	☐ Alzheimer's Disease
☐ High Blood Pressure	☐ Colon Cancer	☐ COPD	☐ Kidney Stones	☐ Anxiety Disorder
☐ Transient Ischemic Attack	☐ Colon Polyps	☐ Oxygen Dependence	☐ Kidney Disease	☐ Bipolar Disorder
☐ Stroke	☐ Irritable Bowel Syndrome	☐ Sleep Apnea	☐ End Stage Renal Disease	☐ Dementia
☐ Vascular Disease	☐ Ulcerative Colitis	☐ Gallstones	☐ Hepatitis A	☐ Depression
☐ Blood Clots (Leg)	☐ Crohn's Disease	☐ Cirrhosis	☐ Hepatitis B	☐ Frailty
☐ Blood Clots (Lung)	☐ Celiac Disease	☐ Pancreatitis	☐ Hepatitis C	☐ Wheelchair Bound
☐ High Cholesterol	Other:	Other:	☐ HIV	Other:

Previous Procedures/Surgeries				
☐ None				
☐ Abdominal Aortic Aneurysm (AAA) Repair	☐ Colon Resection	☐ Appendectomy	☐ Lung Lobectomy	☐ Bilateral Tubal Ligation
☐ Cardiac Cath – with stent placement	☐ Small Bowel Resection	☐ Exploratory Laparoscopy	☐ Thyroid Removed	☐ Hysterectomy- Abdominal
☐ Coronary Artery Bypass Graft	☐ Hemorrhoidectomy	☐ Hernia- Abdominal Wall	☐ Lumpectomy, Breast	☐ C-Section
☐ Defibrillator Placement	☐ Fundoplication-Nissen (Hiatal Hernia Repair)	☐ Hernia -Right Inguinal ☐ Hernia - Left Inguinal	☐ Mastectomy, Left ☐ Mastectomy, Right	☐ Gastric Bypass
☐ Pacemaker Placement	☐ Gallbladder Removed	☐ Hernia Repair- Umbilical	☐ Joint Replacement (Specify site)	☐ Gastric Lap Band
☐ Heart Valve Replacement	Other:	Other:	Other:	Other:

Diagnostic Studies/Tests				
☐ None				
☐ Colonoscopy	☐ CT Abd/Pelvis	☐ MRI Abd/Pelvis	☐ Ultrasound Abd/Pelvis	☐ Blood Tests
☐ EGD	☐ CT Chest	☐ PET Scan	☐ ERCP	
Other:	Other:	Other:	Other:	Other:

Social History			
Alcohol	☐ None		
☐ Daily	☐ Weekly	☐ Socially	
Drug Use	☐ None		
☐ Marijuana	☐ Recreational/ Street Drugs		
Tobacco	☐ Never Smoker	☐ Former Smoker	
☐ Current everyday smoker	☐ Current some days smoker	☐ Light tobacco smoker	☐ Heavy Tobacco smoker

	Date Started	**Date Quit**	**Quantity**
☐ Cigarettes			
☐ Cigars			
☐ Chewing Tobacco			
☐ Smokeless/Vaping			

Family Medical History: Check all that apply

☐ No Family History of Colon Cancer ☐ No knowledge of Family History ☐ Patient is adopted

Relation	Alive	Age at Death	Colon Cancer	Rectal Cancer	Colon Polyps	Ulcerative Colitis	Barrett's Esophagus	Crohn's Disease	Esophageal Cancer	Breast Cancer	Thyroid Cancer	Lung Cancer	Malignant Hyperthermia	Heart Disease	Hypertension	Diabetes	Other:	Other:
Father			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Son			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Daughter			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Review Of Symptoms: Check all that apply (Current or recent symptoms)

☐ Strong Allergic Reactions or Hives	☐ Increased Thirst	☐ Abdominal Pain	☐ Itching
☐ Chest Pain	☐ Increased Hunger	☐ Change in Bowel Habits	☐ Rashes
☐ Difficulty Climbing Stairs	☐ Weight Gain	☐ Constipation	☐ Joint Pain
☐ Chest Pain with Activity	☐ Weight Loss	☐ Diarrhea	☐ Muscle Pain
☐ Short of Breath - Exertion	☐ Blurry Vision	☐ Heartburn	☐ Headaches
☐ Fatigue	☐ Vision Changes	☐ Nausea	☐ Seizures
☐ Fever	☐ Frequent Urination	☐ Vomiting	☐ Anxiety
☐ Chills	☐ Urethral Discharge or Incontinence	☐ Black Tarry Stools	☐ Depression
☐ Sore Throat	☐ Trouble Urinating	☐ Blood in Stools	☐ Suicidal Thoughts
☐ Runny Nose	☐ Anemia	☐ Hernias	☐ Cough
☐ Throat Tenderness	☐ Bleeding Easily	☐ Swallowing Problems	☐ Breathing Problems
☐ Thyroid Issues or Mass	☐ Transfusion Reaction		

Allergies

☐ No Known Allergies		☐ No known drug allergies		
☐ Adhesive Tape	☐ Shellfish	☐ Aspirin	☐ Erythromycin	☐ Sulfa's
☐ Latex	☐ Iodine	☐ Cephalosporins	☐ Penicillin's	
Other:	Other:	Other:	Other:	

Current Medications and Supplements ☐ See List Provided By Patient

Name	Dose	Times/How taken		Name	Dose	Times/How taken

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies	☐ Yes	☐ No

X_____ _____

Signature of Patient/Responsible Party **Date**

MAT-SU SURGICAL ASSOCIATES

INTERNAL USE ONLY – Reviewed with

☐ **Patient**	☐ **Parent**	☐ **Guardian**	☐ **Not Present**

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Patient Registration Information		
First Name:	Middle Name:	Last Name:
Preferred Name:	Date of Birth:	Sex: ☐ Male ☐ Female
Marital Status: ☐ M ☐ S ☐ W ☐ D	SS#	E-mail:

Race:	Ethnicity:	Preferred Language:
☐ American Indian or Alaska Native ☐ Black or African American ☐ Decline to provide ☐ White ☐ Asian ☐ Other	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to provide	(If not specified, English will be chosen)

Mailing Address	Physical Address (if different)
Street: City: State: Zip:	Street: City: State: Zip:
Cell Phone:	Home Phone:
May we leave a confidential voice mail? ☐ Yes ☐ No	Pharmacy:
Referring Physician:	Primary Care Physician:

Guarantor / Responsible Party		
Name:	Date of Birth:	Sex: ☐ Male ☐ Female
Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian		Other:
Mailing Address:		Cell Phone:

Insurance	
PRIMARY INSURANCE:	SECONDARY INSURANCE:
Subscriber/Member ID#:	Subscriber/Member ID#:
Group #:	Group #:
Subscriber Name:	Subscriber Name:
Relationship to Patient:	Relationship to Patient:
Date of Birth:	Date of Birth:

Emergency Contact and Consent to Disclose Health Information

We respect your right to privacy regarding medical information. Please list the names of individuals with whom we may share information without additional written consent and check the boxes for the type of consent.

Name _____ Relationship _____ Contact Number _____
☐ Emergency Contact ☐ Medical Health Information ☐ Billing Information

Name _____ Relationship _____ Contact Number _____
☐ Emergency Contact ☐ Medical Health Information ☐ Billing Information

BENEFIT ASSIGNMENT / ACKNOWLEDGEMENT OF PRIVACY PRACTICES

☐ (Initial) I certify that the above insurance and demographic information is true and correct to the best of my knowledge. I authorize Mat-Su Surgical Associates, APC to administer medical treatment. The office has my permission to obtain or release medical records from outside sources that may be important for the continuation of my care (or in the best interest of my dependent if I am signing as a parent or guardian).

☐ (Initial) I understand that I have the right to receive and review a written description of how this practice will handle health information about me. This is known as a Notice of Privacy Practices and describes the use and disclosure of health information made and the information practices followed by the employees, staff, and other office personnel of the Providers, and my rights regarding my health information. The current version of the Notice of Privacy Practices is posted in the waiting/reception area and on our website @ matsusurgical.com.

☐ (Initial) I authorize payment of medical benefits to Mat-Su Surgical Associates. I understand that I am financially responsible for all charges, even if not paid by insurance. I authorize the release of any information necessary to secure the payment of benefits. I agree that all charges for medical services rendered that are not directly paid by my insurance will be my responsibility.

X _____ _____

Signature of Patient / Responsible Party **Date**

MAT-SU SURGICAL ASSOCIATES

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FINANCIAL POLICY

Thank you for choosing Mat-Su Surgical Associates for your healthcare needs. We are committed to providing you the best surgical healthcare available. You are required to read and sign our financial policy prior to any treatment. Please feel free to ask any questions. A copy of this policy will be provided to you upon request.

_____ **(Initial) INSURANCE** - As a courtesy to our patients, we bill and participate with most insurance types. It is your responsibility to know your insurance benefits. If you are unsure of your benefits, please contact your insurance carrier with questions. If you do not provide proof of insurance, you will be expected to pay in full at the time of service or make payment arrangements with our billing staff. You will be considered a self-pay patient until the insurance information is provided to our office.

- **PROOF OF INSURANCE –**We must obtain a copy of your insurance card(s) and a copy of a photo ID for billing. Failure to provide us with the correct information will result in the inability to assist you in filing insurance claims.
- **CLAIM SUBMISSION –**As a courtesy to our patients, we will submit claims. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their requests.
- **CO-PAYMENT/CO-INSURANCE/DEDUCTIBLE** – Co-pays are due at time of service. Co-pays, co-insurance, and deductibles are part of your contractual obligation with your insurance company and are patient responsibility.
- **SCREENING COLONOSCOPY-** Prior to scheduling a screening colonoscopy, you will have a pre-op exam in the office. The office exam is NOT part of the procedure and will be billed to your insurance carrier. This office visit may be subject to your deductible or co-insurance depending on your insurance plan.
- **NON-COVERED SERVICES** – Please be aware that some or all of the services provided may not be covered or not considered reasonable or necessary by some insurers. It will be your responsibility to pay for these services.
- **CHANGE IN COVERAGE** - If your insurance coverage changes, please notify us as soon as possible, so we can make the appropriate changes to help you receive your maximum benefits.
- **USUAL AND CUSTOMARY –** Our prices are representative of the usual and customary charges for our geographic area. You are expected to pay in full for any balance after insurance.

_____ **(Initial) NON-PAYMENT** – If your account is thirty days past due, you may be contacted by our billing department asking for payment in full or to make payment arrangements. If your balance is unpaid after three months, we may refer your account to Cornerstone Credit Services, a collection agency.

_____ **(Initial) CREDIT BALANCE** – A refund will be generated to the responsible party if an account has a credit balance over $10.00. Balances less than $10.00 will be retained and applied to future balances unless a refund is specifically requested.

_____ **(Initial) NO SHOW POLICY** – any patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least a 24-hour notice will be considered a 'No Show' and charged a $75.00 fee.

_____ **(Initial) SELF-PAY ACCOUNTS –** You are required to bring a minimum of $200 toward the initial office visit. If the total balance due is more than you are able to pay at time of service, reasonable payment arrangements may be made by signing a self-pay financial agreement.

I acknowledge that I have read and agree to the above Financial Policy.

X _____

Signature of Patient / Responsible Party **Date**