CENTRAL ALABAMA SURGICAL AND TRAUMA ASSOCIATES

First Name | Middle Initial | Last Name

_____ _____ _____

Social Security Number | Date of Birth | Male or Female

Mailing Address | City | State | Zip Code

_____ _____ _____

Home Telephone Number | Work Telephone Number | Cellular Telephone

Marital Status: Married: ____Single: ____Divorced: ____Widowed: ____

Employer | Employers Address, City, State, and Zip Code

RESPONSIBLE PARTY

_____ _____ _____

Responsible Party Name | Relationship | Responsible Party #'s

Responsible Party Mailing Address

INSURANCE INFORMATION

_____ _____ _____

Primary Insurance Company | Primary Insured's Name | Insured's Date of Birth

_____ _____ _____

Secondary Insurance Company | Secondary Insured's Name | Insured's Date of Birth

LIST ANY PERSONS TO WHOM YOU WILL ALLOW ACCESS OF YOUR MEDICAL RECORDS

Name/Relationship/Contact Information:_____

Name/Relationship/Contact Information:_____

By signing this form, I hereby acknowledge receipt of the "Notice of Privacy Practices"

Signature: _____ Date: _____

Please initial the following statements:

_____ I herewith authorize the release of any medical information necessary to process my claim.

_____ I herewith assign insurance and other payments for surgical/medical services to CASTA.

REGARDLESS OF INSURANCE COVERAGE, I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF ALL CHARGES INCURRED FOR SERVICES RENDERED TO ME OR THE PATIENT NAMED ABOVE.

Signature:_____ Date: _____

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ASSOCIATES

NEW PATIENT QUESTIONNAIRE

Name: _____ Age: _____ Date of Birth: _____
Regular Doctor: _____ Referred By: _____

Reason for Visit: _____
Please list all major symptoms: _____

When did they start? _____

MEDICAL HISTORY

Have you been diagnosed or are you being treated for any medical conditions?
Please List: _____

Surgical History

List all surgeries that you have had and approximate year: _____

_____

Any problem with anesthesia? No _____ Yes _____

MEDICATIONS TAKEN AT HOME

Please list all prescription medications you currently take:

_____

_____ I am currently not taking any prescription medications

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Name of pharmacy that you use: _____ Phone # _____

Please list any non-prescription medication, dietary supplements, vitamins, herbs or minerals that you are currently taking:

_____

_____

_____ I am not currently taking any non-prescription medications, dietary supplements, vitamins, herbs or minerals.

SOCIAL HISTORY

Do you use tobacco? No ____ Yes ____ Never ____

Cigarette ____packs/day _____ Other: _____

Do you drink alcohol? Y / N _____Occasional _____ Moderate

Do you use drugs (recreational)? Y / N _____ Occasional _____ Moderate

FAMILY HISTORY

Please list any immediate family members who have had significant medial problems such as:

Cancer: _____

Stroke: _____

High Blood Pressure: _____

Diabetes: _____

Heart Disease: _____

Bleeding Disorder: _____

Other: _____

ALLERGIES: Please list any medications, food or chemicals that cause your allergies.

1. _____ 3. _____

2. _____ 4. _____

5._____

REVIEW OF SYSTEMS

Check any symptoms that apply to you. If this is a chronic problem, note how long it has been on going.

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GENERAL

□ Fever / chills
□ Weight gain / loss
□ Fatigue
□ Poor appetite
□ Hot flashes

GASTROINTESTINAL

□ Stomach pains
□ Heart burn
□ Constipation
□ Diarrhea
□ Black or bloody stool

URINARY

□ Blood in urine
□ Painful urination
□ Frequent urination
□ Night time urination
□ Urinary incontinence

MUSCULOSKELETAL

□ Back pains
□ Joint pains
□ Muscle pain

ALLERGY

□ Asthma
□ Seasonal Allergies
□ Immunodeficiency

ENDOCRINE

□ Skin/Hair changes
□ Thirsty a lot/Always hot

PULMONARY

□ Chronic cough
□ Coughing blood
□ Wheezing
□ Shortness of breath

CARDIOVASCULAR

□ Chest pains
□ Shortness of breath
□ Rapid or Irregular Heart beat
□ Ankle swelling
□ Leg pain with walking

NEUROLOGIC

□ Numbness / tingling
□ Weakness
□ Dizziness
□ Tremors

ENT/EYES

□ Headaches
□ Difficulty hearing
□ Difficulty seeing
□ Sinus trouble
□ Nose bleeding
□ Sneezing/watery-eyes