CENTER FOR HERNIA REPAIR

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JONATHAN YUNIS MD FACS
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Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____
First Middle Last

Male ❑ Female ❑ Date of Birth:_____ Social Security #: _____

Marital Status: Single ❑ Married ❑ Partnered ❑ Divorced ❑ Widowed ❑

Local Address:_____
Street Unit # City State Zip

Phone: _____Cell Phone: _____ Preferred Phone: _____

Out of State Address:_____
Street Unit # City State Zip

Email:_____

EMERGENCY/ALTERNATE CONTACT

Name:_____ Phone: _____Relation: _____

Name:_____ Phone: _____Relation: _____

INSURANCE INFORMATION

Primary Carrier: _____

Secondary Carrier: _____

If you are <u>NOT</u> the primary card holder, please fill out:

Policy Holder's Name: _____ Date of Birth: _____Relation: _____

MEDICAL RECORDS RELEASE – PATIENT PAYMENT – ASSIGNMENT OF BENEFITS

I hereby authorize Center for Hernia Repair (CFHR) to furnish my medical information to insurance carriers, referring physicians and/or any persons I designate. I give permission for any of my medical records, x-rays, other hospital test(s) and/or any additional information contained in my medical records to be sent to CFHR via mail or fax. I also assign CFHR all payments for medical services rendered to myself and/or my dependent(s). I understand that I am responsible for all co-pays and/or balances not covered by my insurance carrier and that all payments are to be rendered at time of service. If my account becomes delinquent and is not resolved in a reasonable amount of time it may be turned over to our outside collection agency Gulf Coast Collection Bureau.

Signature:_____ Date: _____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Center for Hernia Repair may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPO). Please refer to Center for Hernia Repair Notice of Privacy Practices for a more complete description and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Center for Hernia Repair reserves the right to revise its Notice of Privacy Practices at anytime.

With my consent, Center for Hernia Repair may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Center for Hernia Repair may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Center for Hernia Repair may send email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Center for Hernia Repair restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Center for Hernia Repair use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Center for Hernia Repair may decline to provide treatment to me.

_____ _____

Patient Signature Date

_____

Printed Name of Patient

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CLINICAL INFORMATION

Name: _____ **Age:** _____ **Today's Date:**_____

Please describe the problem or symptom that you are being seen for today:

_____

_____

How long has this been going on?_____

Where in your abdomen do you have the complaint? Right Side ❑ Left Side ❑ Central ❑

What makes the symptoms better? _____

What makes the symptoms worse?_____

How often do you experience symptoms from your hernia? Never Occasionally Daily Weekly

On a scale of 1-10 (1 = very little; 10 = severe)

What would you rate your pain? _____

OCCUPATION

Are you currently working? Yes ❑ No ❑ Retired ❑

What kind of work are you doing or did you do in the past? _____

FAMILY HISTORY

Is there any family member that has or had a hernia? Yes ❑ No ❑

If yes, relation? _____Age of onset?_____

Please list your mother's and father's medical diagnoses and/or cause of death (if known):

Mother_____Father _____

SOCIAL HISTORY

Do you currently smoke cigarettes or cigars? Yes ❑ No ❑

Did you quit smoking – Less than 1 month ago Less than 1 year ago Greater than 1 year ago

Please list physical activities that you engage in greater than 2 times per week:

_____

_____

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SURGICAL HISTORY

Have you had previous hernia surgery? Yes ❑ No ❑

Type of Hernia Repair:_____ **DATE:** _____

Type of Hernia Repair:_____ **DATE:** _____

Type of Hernia Repair:_____ **DATE:** _____

Type of Hernia Repair:_____ **DATE:** _____

Please list any other operations you have had below:

Year		**Operation**	
Year		**Operation**	
Year		**Operation**	
Year		**Operation**	
Year		**Operation**	
Year		**Operation**	
Year		**Operation**	

PAST MEDICAL HISTORY

Please **MARK** if you have been **DIAGNOSED** with any of the following conditions:

Hypertension – High Blood Pressure ❑
Diabetes ❑
COPD / Emphysema / Sleep Apnea ❑
Liver Disease / Cirrhosis / Ascites ❑
Kidney Disease or **Renal Insufficiency** ❑
MRSA / C Diff ❑
Crohn's Disease / Ulcerative Colitis ❑
Coronary Artery Disease / Heart Attack / CHF ❑
Atrial Fibrillation / Arrhythmia ❑
Aortic Aneurysm ❑
Bleeding Problem ❑
Deep Venous Thrombosis / Pulmonary Embolism ❑
Cancer – Type: _____ ❑
Other _____ ❑

Please **MARK** below procedures that you have had in the past:

Pacemaker ❑
Heart Bypass ❑
Heart (Coronary Artery) Stent ❑
If so, when? _____
AICD ❑
Valve Replacement ❑

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MEDICATIONS

Medication		**Dose**		**Times per Day**	
Medication		**Dose**		**Times per Day**	
Medication		**Dose**		**Times per Day**	
Medication		**Dose**		**Times per Day**	
Medication		**Dose**		**Times per Day**	
Medication		**Dose**		**Times per Day**	
Medication		**Dose**		**Times per Day**	
Medication		**Dose**		**Times per Day**	

ALLERGIES

List any medicine that you are allergic to (if any):

Medicine		**Reaction**	
Medicine		**Reaction**	
I have no allergies to any medications ❑			

Please **MARK** if you have experienced any of the following symptoms in the **LAST 3 MONTHS:**

Weight Loss Greater than 20 Pounds ❑
Fever or Chills of Unknown Cause ❑
Chest Pain ❑
Shortness of Breath ❑
Diarrhea ❑
Trouble Urinating ❑
Nausea ❑
Vomiting ❑
Blood in Stool ❑
Constipation ❑
Abdominal Pain ❑
Back Pain ❑
Joint Pain ❑
Bleeding Problem(s) ❑
Awaking from Sleep to Urinate more than 3 Times a night ❑

Are you interested in improving the appearance of your abdomen at the time of your surgery with a "tummy tuck" (abdominoplasty)? Yes ❑ **No** ❑

Dr Yunis is very motivated to listen and communicate accurately with his patients. Please make sure that your personal motivations or concerns are discussed prior to making any decisions for surgery.