Surgical Alliance of Middle Tennessee

PATIENT INFORMATION

NAME ____ DATE ____________

ADDRESS ________________________________CITY ________________ STATE _____ ZIP_______

DATE OF BIRTH ______________ AGE ________ GENDER M / F MARITAL STATUS ____

EMAIL ADDRESS ____

SSN ______________________ HOME PHONE ________________ CELL PHONE_________________

REFERRING PHYSICIAN _____________________________________ PHONE ___________________

PERSON RESPONSIBLE FOR ACCOUNT ____

EMPLOYER _____________________________________ WORK PHONE _______________________

NEAREST RELATIVE _____________________________ RELATIVE'S PHONE _________________

DO YOU HAVE A LIVING WILL? ________ PHARMACY/ PHONE# _________________________

INSURANCE INFORMATION

DO YOU HAVE INSURANCE COVERAGE YES NO ***SPECIALIST*** CO-PAY AMOUNT_______

PRIMARY INS ________________________________ INSURED'S NAME______________________

POLICY HOLDER ________________________ DOB _______ SSN ____________________________

POLICY HOLDERS ADDRESS (if different than above) _______________________________________

CITY ________________________ STATE_____ ZIP ________ PHONE _________________________

INSURANCE ID # ________________________ GROUP _________________

SECONDARY INS ______________________________ INSURED'S NAME_____________________

POLICY HOLDER ________________________ DOB _______ SSN ____________________________

POLICY HOLDERS ADDRESS (if different than above) _______________________________________

CITY ________________________ STATE_____ ZIP ________ PHONE _________________________

INSURANCE ID # ________________________ GROUP _________________

BY SIGNING BELOW, I AGREE TO ALLOW SURGICAL ALLIANCE OF MIDDLE TENNESSEE TO RELEASE ANY INFORMATION TO MY INSURANCE CARRIER TO FILE MY INSURANCE. I ALSO AGREE TO PAY MY CO-PAYMENTS AND ALL AMOUNTS APPLIED TO DEDUCTIBLE/ COINSURANCE. IF MY ACCOUNT IS SENT TO COLLECTIONS, I ALSO AGREE TO PAY FOR COLLECTION CHARGES AND ASSOCIATED FEES INCLUDING ATTORNEY AND COLLECTION AGENCY FEES.

PATIENT SIGNATURE ____ DATE_______________

Pre-Anesthesia Assessment Form

Contact Information

Patient Name:	Date of Birth:_____________ Age:___ Gender: ☐ M ☐ F
Phone #1:____________________ Best time to Call: AM/PM May we leave a message? ☐ Yes ☐ No	Phone #2:____________________ Best time to Call: AM/PM May we leave a message? ☐ Yes ☐No
Primary Language: ☐ English ☐ Spanish ☐ Other___________________	

	Please indicate by checking "**Yes**" or "**No**", if you currently have or previously had any of the following conditions or medical treatments:	YES	NO
PERSONAL HISTORY	Have you or a family member ever had a problem with anesthesia? Malignant		
	Do you have metal anywhere in your body (plates, screws, joint replacements, and vascular		
	Have you ever been diagnosed with sleep apnea?		
	Do you use a CPAP machine?		
	Do you have a Living Will or Advance Directive?		
	Do you have Home Health visiting you at present?		
	Do you ever feel threatened by your partner, child, caregiver or anyone in your home?		
	Do you have any physical restrictions?		
	What would you consider your level of activity to be? ☐ Very Light ☐ Light ☐ Moderate ☐ High		
	Do you live alone?		
	Do you need help with your normal daily activities?		
	Do you use a wheelchair, walker or cane on a regular basis?		
	Do you have any culture or religious practices that are important to you during your visit with us?		
	Would you accept blood products/transfusion if needed?		
	Do you smoke or vape? Packs/Day_____ How many yrs? ______		
	Do you drink alcohol? How much? _________ How often? ___________		
	Do you use recreational drugs? Specify:_________________________________		
	How do you like to learn new things? ☐ Reading ☐Watching ☐Listening		
	What pharmacy do you use?		
	Primary Care Physician:		

HEART	Do you see a Cardiologist? Who:______________ Last Visit: ________ Last		
	Ankle Swelling		
	Congenital Heart Problems		
	High Cholesterol		
	High blood pressure or vascular disease		
	Heart valve disease (ex: Tricuspid, Mitral, Aortic, or Pulmonic valve)		
	Congestive heart failure		
	Irregular heartbeat		
	Do you have a cardiac pacemaker or defibrillator?		
	Aneurysms of the brain or vasculature (ex: Aortic aneurysm)		
	Coronary artery disease. If so, have you had heart bypass surgery (CABG)? **YES or NO**		
	Do you experience chest pain or tightness at any time? (ex: while resting, exercising)		
	Do you experience shortness of breath at any time? (ex: while resting, exercising)		
	Have you ever had a heart attack? If so, when (month/year)? _________________________		
	Do you have any cardiac stents? If so, when were they placed (month/year)? ___________		
LUNGS	Recent respiratory infection/Pneumonia		
	Chronic Obstructive Pulmonary Disease (COPD)		
	Chronic Bronchitis or Empysema		
	Severe Asthma (ex: requiring Emergency Room treatment)		
	Tuberculosis		
	Do you wear oxygen at home? If so,_______L/min		
	Have you been diagnosed with Sleep Apnea? If so, do you wear a CPAP? **YES or NO**		
NEURO	Paralysis/Weakness		
	Frequent Headaches/Migraines		
	Alzheimer's Disease		
	Seizure disorder (ex: Epilepsy)		
	Have you ever had a stroke (CVA) or mini-stroke (TIA)		
	Multiple sclerosis, muscular dystrophy, myasthenia gravis or other muscular disorders		
	Neuropathy (numbness) of the hands, feet, or legs		
	Chronic back pain, neck pain, or scoliosis		
	Severe anxiety or depression		
	Post-Traumatic Stress Disorder (PTSD) or Claustrophobia		
	Chronic Pain Syndrome or Fibromyalgia		

Please indicate by checking "**Yes**" or "**No**", if you currently have or previously had any of the following conditions or medical treatments:		**YES**	**NO**
	Hyperthyroidism or Hypothyroidism		

E N D O C R I N E / G I / R E N A L	Diabetes. If so, do you require insulin for treatment? **YES or NO**		
	Gastroesophageal Reflux (GERD) or severe Heart Burn/Indigestion		
	Hiatal Hernia		
	Ulcers of the stomach		
	Liver disease (ex: Hepatitis, Cirrhosis)		
	Prostate problems		
	Blood in urine		
	Frequent infections		
	Kidney disease		
	Kidney Failure		
	Are you currently receiving dialysis? If so, last treatment date (day/month)? ____		
	Kidney Stones		
	Frequent urination, urgency or leakage		
H E M E	Bleeding disorders (ex: Anemias or Clotting disorders)		
	Blood clots (ex: Deep Vein Thrombosis or Pulmonary Embolism)		
	Are you currently taking blood thinners? (ex: Aspirin, Warfarin, Eliquis, Plavix)		
	Have you ever received a blood transfusion?		
	Autoimmune or Connective tissue disorders (ex: Lupus, Rheumatoid Arthritis)		
	Infectious diseases (ex: Hepatitis, HIV/AIDS, MRSA, VRE)		
S K I N / B O N E	Sore that won't heal		
	Open wound		
	Wound Care Patient ☐ Current ☐Past		
	Arthritis/Gout		
	Foot problems		
M I S C	As a child, were you diagnosed with any congenital abnormalities		
	History of alcohol or drug abuse		
	Are you currently receiving radiation or chemotherapy?		
	Have you ever received radiation to the face, neck, or upper chest?		
	Do you have any implantable devices? (ex: bladder/spinal cord stimulator, insulin pump)		
	Last menstrual cycle? ☐ Hysterectomy ☐Post-Menopausal		

Please indicate by checking "**Yes**" or "**No**", if you currently have or previously had any of the following conditions or medical treatments:		YES	NO
	Blurred or double vision		
	Cataracts		

	Blindness/Macular Degeneration		
	Ear problems		
	Loss of hearing		
	Loss of balance		
	Hoarseness		
	Difficulty swallowing		
	Sinus problems		
ANESTHESIA	Have you ever had neck surgery, jaw surgery, or nose surgery?		
	Have you ever been told you were a difficult airway by other anesthesia providers?		
	Do you experience nausea and vomiting post-op after receiving anesthesia?		
	Have members of your family ever had life threatening problems with anesthesia?		
	Have you ever had life threatening problems with anesthesia? (please describe below)		
	Please list any additional complications from anesthesia, health concerns, or questions you may have for the Anesthesia provider in the space provided below.		
FAMILY HISTORY	Heart disease		
	High blood pressure		
	Kidney disease		
	Blood disease		
	Diabetes		
	Thyroid disease		
	Mental illness		
	Neurological disease		
	Cancer – Type: ______________________________		
	Other: ______________________________		

Please list all Allergies and Reactions in the space provided below.

ALLER	**Allergies**	**Reaction**
	1)	
	2)	
	3)	

GIES		
	4)	
	5)	
	6)	

Please list all Medications, Supplements, or Herbals you are currently taking in the space provided below.

MEDICATIONS	Name, Dose & Frequency	
	1)	8)
	2)	9)
	3)	10)
	4)	11)
	5)	12)
	6)	13)
	7)	14)

Surgeries, Implantable Devices, and Metal Implants in the space provided below. Check all that apply.

☐ NONE	☐ Colonoscopy/EGD	☐ Kidney Removal	☐ Total Hip ☐ Left ☐ Right
☐ Aneurysm (AAA)	☐ Colon Resection	☐ Cystoscopy	
☐ Angiogram (other than heart)	☐ Mastectomy ☐ Left ☐ Right	☐ Cataract ☐ Left ☐ Right	☐ Total Knee ☐ Left ☐ Right
☐ Heart Bypass	☐ Hernia	☐ Prostate	☐ Arthroscopy ☐ Knee ☐ Shoulder
☐ Heart Cath/Stents	☐ Hemorrhoidectomy	☐ Lithotripsy	
☐ Pacemaker/Defibrillator	☐ Laparoscopy	☐ D & C	☐ Foot, Ankle or Knee
☐ Fem/Pop Bypass	☐ Breast Biopsy	☐ Hysterectomy	☐ Hand or Wrist
☐ Heart Valve	☐ Appendectomy	☐ Tubal Ligation	☐ Shoulder or Elbow
☐ Carotid ☐ Left ☐ Right	☐ Gallbladder	☐ Cesarean Section	☐ Carpel Tunnel Release
☐ Silverhawk	☐ Amputation	☐ Spine (Back/Neck)	☐ Ear tubes
☐ AV Grafts	☐ Splenectomy	☐ Spinal Injections	☐ Sinus
☐ Gastric Bypass	☐ Bladder Repair	☐ Ablation	☐ Tonsils and Adenoids
☐ Thyroid	☐ Other:___________________		

For Office Use:

Please Indicate Below If Surgeon Is Requesting Any Clearances Or Testing Be Completed Prior To Surgery

Cardiac Clearance **Medical Clearance** **Pulmonary Clearance** **Pre-Admission Testing**

PAT Date: ____________

SURGICAL ALLIANCE PRIVACY POLICY
AND
CONTACT INFORMATION SIGNATURE SHEET

Notice of Privacy Practices

By signing below I indicate that I have been given the opportunity to review and receive a copy of the Privacy Practice Policy of the Surgical Alliance of Middle Tennessee.

Contact Information

Patient Name: ____

(Please check ALL that apply)

Home telephone # ____________________________

☐ Leave message with call back information ***ONLY***.
☐ Okay to leave detailed message.
☐ Do not contact me at this number.
☐ Do not leave messages at this number.

Work telephone # ____________________________

☐ Leave message with call back information ***ONLY***.
☐ Okay to leave detailed message.
☐ Do not contact me at work.
☐ Do not messages at the number.

Cell phone # ________________________________

☐ Leave message with call back information ***ONLY.***
☐ Okay to leave detailed message.
☐ Do not contact me on my cell phone.
☐ Do not leave messages at this number.

Written communication

☐ Okay to mail sensitive information to my home address.
☐ Send all written communications to P.O. Box

Disclosing your health information to other individuals:

☐ Do not release any information to anyone except me.
☐ You have my permission to disclose information to the following person(s):

___________________________________ ___________________________________

___________________________________ ___________________________________

____ ______________

Patient/Guardian Signature Date

Authorization to Release Medical Records

______________________________ ____________________ ________________
Print Patient's Name Social Security Number Date of Birth

____
Address City State Zip Code

I request and authorize: **Surgical Alliance of Middle Tennessee, PLC**
417 NorthCrest Drive
Springfield, TN 37172

Phone: (615) 384-8211
Fax: (615) 384-8502

- To Provide to:
- To Receive from:

Name: ____

Address: ____

____

Phone: ___________________________ Fax: _______________________________

For the purpose of: Continued medical care (please include name and address of physician you will be seeing) Moving Personal use other

Method of Delivery (please circle one): Fax Mail Hold for pick up

Records Requested:

- ☐ All available records
- ☐ History and Physical
- ☐ Medical Imaging
- ☐ Operative Reports
- ☐ Hospital Admissions
- ☐ Pathology Reports
- ☐ Laboratory Results
- ☐ Other ______________________________________

____
Patient Signature Date

Faxed By: Date: