Valley Surgical Associates

Kyle Bess, MD
Douglas Downey, MD, FACS
Matthew Hunt, MD, FACS
Veeraiah Siripurapu MD, FACS
Marc Zelickson, MD

Dear Patient,

We would like to take this opportunity to thank you for choosing Valley Surgical Associates for your health care needs and to welcome you to our office. We are pleased that you have chosen us to provide you with medical services.

Our website – *huntsvillehospital.org/valley-surgical-associates* – should help answer any questions you have about our office. We want you to know about our office services and what to expect at the time of your first visit.

Please complete the enclosed forms prior to your appointment, and bring them with you on the day of your visit. You should also bring your identification cards, insurance information and medication list, as well as your co-payments and/or deductibles.

If you are unable to keep this appointment or are going to be more than **15 minutes** late, please call our office at (256) 817-5951 as soon as possible. We will be happy to reschedule a more convenient time for you.

We look forward to seeing you. If you have any questions, please do not hesitate to contact us.

Sincerely,

Jackie Jennings, RN
Clinical Practice Manager
Valley Surgical Associates

Madison Medical 1
8371 Highway 72, Ste. 206
Madison, AL 35758
o: (256) 817-5951
f: (256) 817-5952

Blackwell Medical Tower
201 Sivley Road, Ste. 330
Huntsville, AL 35801
o: (256) 817-5951
f: (256) 817-5952

Valley Surgical Associates

PLEASE PRINT **(Please use Black or Blue Ink ONLY)** **Patient Information Form**

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Work Phone ( ) _____ Ext. _____ Preferred Contact: ☐ Home Phone ☐ Cell Phone ☐ Letter

SS#: _____ - _____ - _____ Sex: M or F Age: _____ Date of Birth: _____ / _____ / _____

☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single Email: _____

Patient's Employer: _____ Occupation: _____

Employer's Address: _____

(Please provide Account Guarantor's Information, when the patient is a minor)

Spouse or Account Guarantor's Name: _____ Date of Birth: _____ / _____ / _____

SS#: _____ - _____ - _____ Occupation: _____

Employer: _____ Phone: ( ) _____

Notify In Case of Emergency: _____ Relationship: _____

Phone: ( ) _____ Cell Phone: ( ) _____

Referred by (Physician): _____ Phone: ( ) _____

Primary Care Physician _____ Phone: ( ) _____

Result of on the job injury: _____ Result of Accident: _____ Date of Injury: _____

(Provide Guarantor's Information only when patient is a minor otherwise provide patient's information) PRIMARY INSURANCE

Insurance Name:	Relationship to Patient:
Subscriber' Name:	Copay Amount:
Subscriber ID/Contract/Policy#:	Group#:
Subscriber's Social Security#:	Subscriber's Date of Birth:
Subscriber's Employer:	Employer's Phone:

SECONDARY INSURANCE

Insurance Name:	Relationship to Patient:
Subscriber' Name:	Copay Amount:
Subscriber ID/Contract/Policy#:	Group#:
Subscriber's Social Security#:	Subscriber's Date of Birth:
Subscriber's Employer:	Employer's Phone:

PERSON RESONSIBLE FOR THIS ACCOUNT _____ Phone: ( ) _____

When applicable, I agree that payment will be made at the time of service. I agree to pay all co-pays, non-covered or routine charges, deductibles and co-insurance amounts that apply. In the event this account is turned over to a collection agency for collection, I will be responsible for all collection fees, court costs, or attorney's fees. I authorize North Alabama Surgical Associates to release information to insurance carriers and for insurance carrier's to release information to North Alabama Surgical Associates concerning my illness, treatment and payments (including workmen's compensation) and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents if assignments applies.

Signature of Responsible Person _____ **Date** _____ **Time:** _____

CHART # _____

Valley Surgical Associates **HISTORY AND PHYSICAL**

Name SS # Date

Address Date of Birth

Phone (Home) (Work) Email

Referring Physican Primary Care Physican

Reason for visit

WHAT ARE YOUR MAIN CONCERNS OR QUESTIONS TODAY?

DESCRIPTION OF PRESENT ILLNESS

When did your symptoms start?

CURRENT MEDICATIONS

Name	Dose	Name	Dose

DRUG ALLERGIES

Medications	Reactions
1)	
2)	
3)	

Latex Allergy: Y___ N___

PAST MEDICAL HISTORY

- ☐ Headache
- ☐ Epilepsy / Seizures
- ☐ Stroke
- ☐ Head Injury / Concussion / Whiplash
- ☐ Spinal Cord Injury
- ☐ Arthritis _____ (type)
- ☐ Peripheral Nueropathy
- ☐ Brain Tumor
- ☐ Depression or Anxiety
- ☐ Coronary Artery Disease / MI
- ☐ Irregular Heartbeat / Atrial Fibrillation
- ☐ Congestive Heart Failure
- ☐ Murmur
- ☐ High Blood Pressure
- ☐ Fibromyalgia
- ☐ Cancer _____ (type)
- ☐ Tuberculosis
- ☐ HIV / AIDS
- ☐ Alcohol Use:
  - ☐ # drinks per day _____
  - ☐ # drinks per year _____
- ☐ Smoking:
  - ☐ Current or past smoker
  - ☐ # packs per day _____
  - ☐ # packs per year _____
- ☐ COPD / Emphysema
- ☐ Pneumonia
- ☐ Asthma
- ☐ GERD / Acid Reflux
- ☐ Colon Polyps
- ☐ Bleeding Disorder
- ☐ Anemia
- ☐ Diabetes _____ (type)
- ☐ Peripheral Vascular Disease
- ☐ Thyroid Disease
- ☐ Menstrual / Sexual Dysfunction
- ☐ Other Endocrine
- ☐ Liver Disease / Hepatitis
- ☐ Kidney Problems
- ☐ Bladder Problems
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Allergy / Hay Fever
- ☐ Carotid Artery Disease
- ☐ Autoimmune Disease (Lupus, etc.)
- ☐ High Cholesterol
- ☐ Sleep Apnea
- ☐ Other _____

PAST SURGICAL HISTORY

- ☐ Amputation
- ☐ AV Fistula Creation
- ☐ AV Graft
- ☐ Aortic Valve Replacement
- ☐ Appendectomy
- ☐ Legs Bypassed Right / Left
- ☐ Back Surgery
- ☐ Bronchoscopy (Lung Scope)
- ☐ CABG (Heart Bypass)
- ☐ Carotid Endarterectomy
- ☐ Carpal Tunnel Right / Left
- ☐ Cataract Extraction
- ☐ Gallbladder Removed
- ☐ Colon Resection
- ☐ Craniotomy
- ☐ Gastric Bypass
- ☐ Hemorrhoidectomy
- ☐ Hip Replacement Right / Left
- ☐ Invasive Pain Procedure
- ☐ Kidney Transplant
- ☐ Knee Arthroscopy
- ☐ Knee Replacement Right / Left
- ☐ Kyphoplasty
- ☐ Lumpectomy
- ☐ Mitral Valve Replaced
- ☐ Nephrectomy
- ☐ Pacemaker Implanted
- ☐ Parathyroidectomy
- ☐ Pneumonectomy
- ☐ PTCA (Angioplasty)
- ☐ Rotator Cuff Repair Right / Left
- ☐ Abd. Hysterectomy
- ☐ Hysterectomy/Ovaries
- ☐ **Ovaries Removed Yes / No
- ☐ Prostate Surgery
- ☐ Shoulder Surgery Right / Left
- ☐ Sleep Apnea Surgery
- ☐ Thyroid Surgery
- ☐ Tonsil's Removed
- ☐ Vascular Surgery
- ☐ Breast Augmentation Right / Left
- ☐ Mastectomy Right / Left
- ☐ Lumpectomy Right / Left
- ☐ Other _____

Advanced Directives: Y____ N ____
(Please provide office a copy for their records)

REVIEW OF SYSTEMS

GENERAL
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Anorexia
- ☐ Fatigue
- ☐ Weakness
- ☐ Malaise
- ☐ Weight Loss
- ☐ Sleep Disorder

RESP
- ☐ Cough
- ☐ Dyspnea at Rest
- ☐ Excessice Sputum
- ☐ Coughing Up Blood
- ☐ Wheezing
- ☐ Shortness of Breath at Rest
- ☐ Emphysema/ Bronchitis
- ☐ Pneumonia
- ☐ Hemopysis

MS
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Stiffness
- ☐ Arthritis
- ☐ Sciatica
- ☐ Leg Pain at Night
- ☐ Leg Pain With Exertion
- ☐ Restless Legs
- ☐ Numbness/Tingling
- ☐ Varicose Veins
- ☐ Phlebitis

ALLERGY
- ☐ Hives
- ☐ Allergic Rash
- ☐ Hay Fever
- ☐ Recurrent Infections

BREAST
- ☐ Lumps
- ☐ Nipple Discharge
- ☐ Do Self Exam

GU
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Discharge
- ☐ Urinary Frequency
- ☐ Urinary Hesitancy
- ☐ Nightime Urination
- ☐ Incontinence
- ☐ Genital Sores
- ☐ Decreased Libido
- ☐ Erectile Disfunction
- ☐ Leakage of Urine
- ☐ Kidney Stones
- ☐ Frequent Infections

DERM
- ☐ Rash
- ☐ Itching
- ☐ Dryness
- ☐ Suspicious Lesions
- ☐ Hair/Nail Problems
- ☐ Lumps
- ☐ Masses

GI
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in Bowel Habits
- ☐ Abdominal Pain
- ☐ Blood in Stool
- ☐ Jaundice
- ☐ Gas/Bloating
- ☐ Indegestion/Heartburn
- ☐ Trouble Swallowing
- ☐ Painful Swallowing
- ☐ Ulcer
- ☐ Hemorrhoids
- ☐ Hepatitis

HEME
- ☐ Bruse Easilly
- ☐ Difficulty Stopping Bleeds
- ☐ Enlarged Lymph Nodes
- ☐ Yellow Jaundice
- ☐ Family History of Bleeding
- ☐ Blood Transfusion

ENT
- ☐ Earache
- ☐ Ear Discharge
- ☐ Ringing of Ears
- ☐ Decreased Hearing
- ☐ Nasal Congestion
- ☐ Nosebleeds
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Allergies
- ☐ Sinus Trouble
- ☐ Goiter/Thyroid
- ☐ Swollen Glands

CV
- ☐ Chest Pains
- ☐ Palpitations
- ☐ Syncope
- ☐ Shortness of Breath on Exertion
- ☐ Orthopnea
- ☐ PND
- ☐ Peripheral Edema
- ☐ Murmur
- ☐ Chest Pain w/exercise
- ☐ Swelling of Ankles
- ☐ Last EKG_____

PSYCH
- ☐ Depression
- ☐ Anxiety
- ☐ Memory Loss
- ☐ Suicidal Ideation
- ☐ Hallucinations
- ☐ Paranoia
- ☐ Phobia
- ☐ Confusion

EYES
- ☐ Blurring
- ☐ Double Vision
- ☐ Irritation
- ☐ Discharge
- ☐ Vision Loss
- ☐ Eye Pain
- ☐ Sensitivity to Light
- ☐ Cataracts
- ☐ Last Eye Exam _____
- ☐ Wear Glasses/Contacts

ENDO
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Excessive Thirst
- ☐ Excessive Hunger
- ☐ Excessive Urination
- ☐ Unusual Weight Change
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Diabetes

NEURO
- ☐ Headaches
- ☐ Dizziness

ALLERGIES
- ☐ Seasonal Allergies

PRIOR HOSPITALIZATIONS

Reason _____

_____

FAMILY HISTORY

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	BROTHER	SISTER	SON	DAUGHTER
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Sudden Death	☐	☐	☐	☐	☐	☐	☐	☐
Rheumatic Disease	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	BROTHER	SISTER	SON	DAUGHTER
Seizures	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐
Neuromuscular	☐	☐	☐	☐	☐	☐	☐	☐
Headaches /Migraine	☐	☐	☐	☐	☐	☐	☐	☐
Autoimmune Disease	☐	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐
Neuromuscular	☐	☐	☐	☐	☐	☐	☐	☐
TB	☐	☐	☐	☐	☐	☐	☐	☐
AIDS	☐	☐	☐	☐	☐	☐	☐	☐

Cancer Type? _____

Completed by: _____ Date: _____

REMARKS

_____

_____

Health System
101 SIVLEY ROAD • HUNTSVILLE, AL 35801 • 256-265-1000

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name _____ SS Number (Optional)_____

Date of Birth _____ Address _____

Phone Number (_____)_____Date of Service_____ Patient Number

I authorize the use or disclosure of the above named individual's health information as described below:

1. Huntsville Hospital is authorized to make the disclosure.

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

☐ Facesheet	☐ Physician Orders	☐ Laboratory Results	Records Release Format
☐ Discharge Summary	☐ Outpatient Record	☐ Imaging Results	☐ e-delivery (Healthport Connect)
☐ History and Physical	☐ Emergency Dept. Record	☐ Bill / Claim Form	☐ CD
☐ Operative Note	☐ EKG Report	☐ Itemized Statement	☐ Paper
☐ Pathology Report	☐ EBC Application	☐ Other_____	
☐ Consultation Report	☐ Autopsy Report		
☐ Progress Notes			

3. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be disclosed to, and used by, the following individual or organization:

   Name: _____

   Address: _____

5. For the purpose of _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. Unless otherwise revoked, the authorization will expire on the following date, event, or condition:

   _____

   If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date of signing.

8. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

9. I understand that as the recipient, I am responsible for the security of these medical record copies and the health information contained therein, whether in paper format or on CD/DVD.

10. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

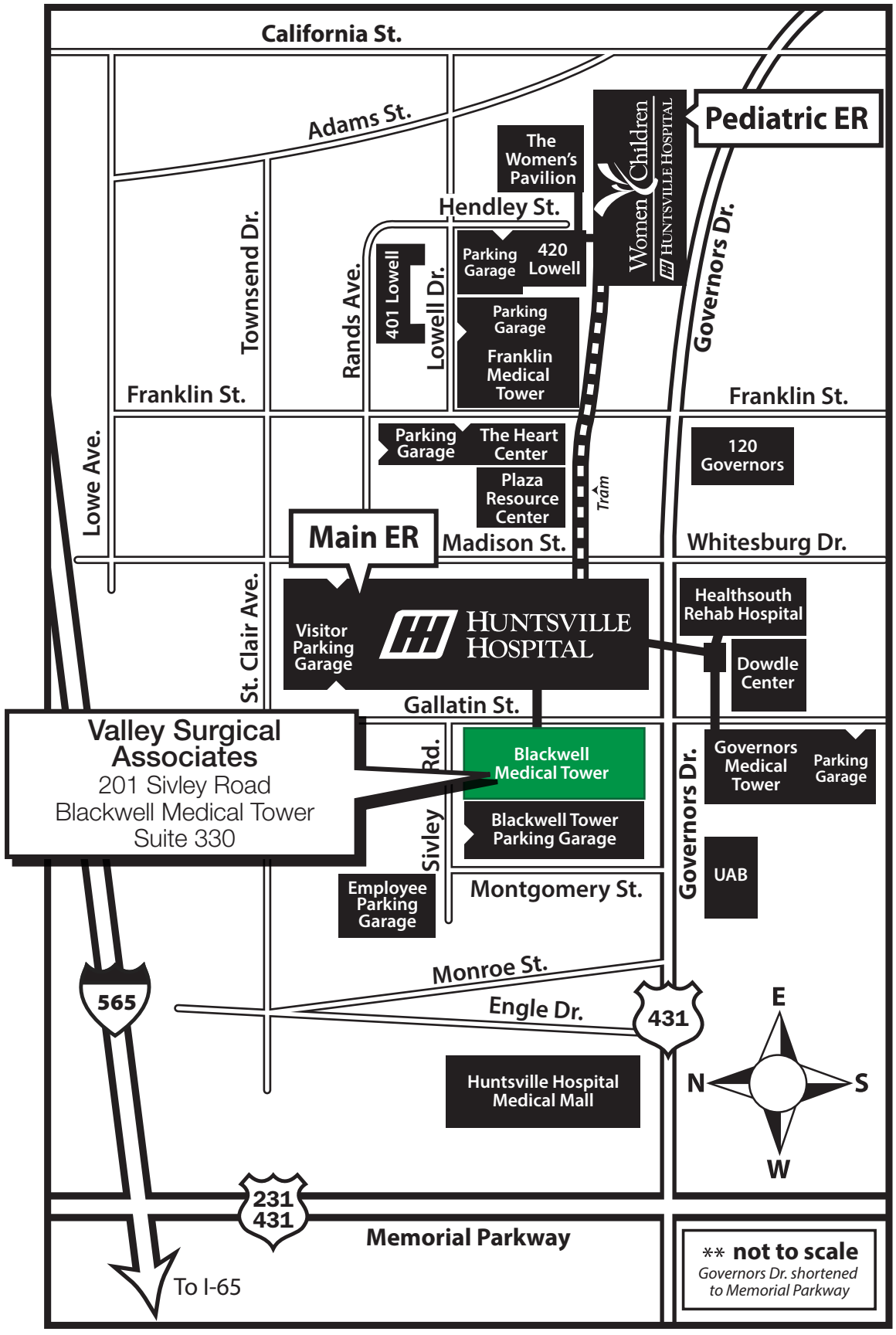
    or

    I understand that if I refuse to sign this form, under specific conditions the organization can refuse:
    Treatment Enrollment in the health plan Eligibility for benefits

_____ _____ _____
SIGNATURE DATE TIME

_____ _____ _____ _____
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT SIGNATURE OF WITNESS DATE TIME

HUNTSVILLE HOSPITAL / Medical District



MADISON HOSPITAL