Cameron S. Askew MD, PC
BARIATRIC AND GENERAL SURGERY

Patient Information

Name: (Last, first, middle initial)__________ Date of Birth:__________

Address: (including apt. number)__________

City, State, Zip Code: __________

Home phone:__________ Work phone:__________ Cell phone :__________

E-mail address:__________ Preferred form of communication with us: __________

Social Security Number: __________

Marital Status: Married_____ Single _____ Divorced _____ Widow _____ Other _____

Race: __________ Language Preference: __________ Employer: __________

Emergency Contact person: __________ Emergency contact number: __________

Relationship:__________

Responsible Party (if not patient) __________ Contact number __________

Who referred you to Dr. Askew? __________

Primary Care Physician: __________ Preferred Pharmacy: __________

PLEASE PRESENT IDENTIFICATION AND INSURANCE CARD TO FRONT DESK AT TIME OF APPOINTMENT

Primary Insurance: __________ Policy Holder: __________

Policy #: __________ Group #: __________ Relationship to patient: __________

Policy Holder date of birth: __________ Specialist Co Pay Amount:__________

Secondary Insurance:__________ Policy Holder: __________

Policy #:__________Group #: __________ Relationship to patient: __________

Policy Holder date of birth: __________

Co-Pays are due at the time of service. In the event you do not provide our office with correct insurance information on the date of your scheduled appointment we will not be held accountable for non-precertification or notification. If insurance is filed according to the information provided by you (the patient) and the claim denies because other insurance is primary or secondary, the bill becomes your full responsibility. It is your responsibility to provide correct insurance information at the time of service. The patient (parent/guardian) is responsible for all fees – regardless of insurance coverage. Should benefits be paid directly to the policy holder by the insurance company, you should forward payment to Askew Bariatric along with a copy of the EXPLANATION OF BENEFITS to be applied to any unpaid balance on your account.

Please list all family/friends who we can discuss your medical records, treatment, test results (etc.)

Name/Relationship/Phone #

____

Name/Relationship/Phone #

____

Date: __________ Patient (Responsible party) Signature:__________

New Patient Medical History Form:

Home Medications:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Drug Allergies:

____
____

Past Medical History: (Circle or write in)

High Blood Pressure
High Cholesterol
Diabetes: Insulin Non-insulin
Obstructive sleep apnea
Osteoarthritis
Back Pain
Joint Pain
GERD/heartburn
Migraines
Heart disease
Anxiety/Depression

____
____
____

Past Surgical History: (Circle or write in)

Gastric Bypass/Sleeve Gastrectomy/Lap Band
Gallbladder removal
Appendectomy
Hysterectomy
Knee surgery
Back surgery
Hip surgery
Tonsillectomy
Hernia repair

____
____

Social History:
Smoke: Current Never Quit ________
Alcohol: ______________________
Illicit Drugs: ______________________

Family History: (Circle & write which family member(s)

Obesity ______________________
Diabetes ______________________
Heart Disease ______________________
Cancer ______________________
High blood pressure ______________________
High cholesterol ______________________

Review of Systems: (Circle)

Weight gain or loss
Shortness of breath with activity
Headaches
dizziness
Abdominal pain
Constipation
bloating
back pain
joint pain
skin infections
rash
poor sleep
waking frequently throughout the night
fatigue
diarrhea
pain with urination
change in urination
urinary incontinence

List your regular doctors if applicable:

Primary Care Doctor: ______________________
Cardiologist: ______________________
Pulmonologist: ______________________
Gastroenterologist: ______________________

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Please Carefully Read and Sign

Treatment:

I, the undersigned, agree to the care and treatment by the attending physician, her/his associated, and/or assistants. The treatment may include but is not restricted to medications, immunizations, anesthesia, surgical and invasive procedures, laboratory tests, x-rays, or other studies that may be helpful in the provision of my/the patient's care. My medical records may be furnished to other physicians as needed for my treatment.

Patient Signature:_______________________________________ Date:____________________

Insurance Information/Payment in Full:

I, the undersigned do confirm that my insurance information is correct and current and I have given you my primary and secondary insurance information if applicable. Co-pays are due at the time of service.

In the event that you do not provide our office with correct insurance information on the date of your scheduled appointment, we will not be held accountable for non-precertification. If insurance is incorrect or claim is denied because another insurance is primary and you did not give us this information, the bill will become your full responsibility. If you provide correct insurance after the fact and insurance denies based on untimely filing you will also be responsible for full charges regardless of the insurance sending a letter that states "No patient responsibility".

I also understand that charges not covered by insurance remain my responsibility and I agree to pay my patient balance. I understand that if I do not pay on my balance within 90 days that my balance will be turned over to a collection agency and I will be responsible for all fees in addition to my balance.

Patient Signature:_______________________________________ Date:____________________

Communication:

I authorize my health care provider and her/his staff to use a telephone system, automated telephone or texting system, and/or email and to use my name, address, phone number and name of treating physician as well as place and time of appointment for the limited purpose of contacting me to notify me of a pending appointment or other limited healthcare related communication. And that this information can be shared with a third party who answers the phone or be left on a voicemail system.

Medical information and/or test results will only be shared with the PATIENT or the following person/persons:

Name/Relationship/Phone #:

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Name/Relationship/Phone #:

____

Patient Signature:_______________________________________ Date:____________________