North Valley Surgical Associates, PC
General & Minimally Invasive Surgery

Brian P. Lipton, M.D., Ph.D., F.A.C.S
Debora J. McClary, M.D., F.A.C.S.
Kara M. Villareal, M.D., F.A.C.S.

www.NorthValleySurgeons.com
(602) 995-0822 OFFICE
(602) 995-0825 FAX

PATIENT DEMOGRAPHICS

PATIENT INFORMATION

Patient: First Name______________________ Middle Initial_______ Last Name______________________

Date of Birth______________________ SSN______________________ Gender: ☐Male ☐Female

Address______________________ Email______________________

City______________________State______________ Zip Code______________

Home Phone___(______)______________________ Cell Phone ___(______)______________________

Occupation______________ Employer______________ Work Phone______________

Marital Status: ☐Married ☐Single ☐Widowed/er ☐Divorced Significant Other's Name______________________

Preferred Language______________ Race______________Ethnicity______________

PHYSICIAN/PHARMACY INFORMATION

Primary Care Provider______________________ Phone Number ___(______)______________

Referring Provider (if different)______________________ Phone Number ___(______)______________

Pharmacy Name______________________ Pharmacy Phone___(______)______________

Pharmacy Location: Cross Streets, City and Zip Code______________________________________

CONTACT INFORMATION

Under current privacy laws, we cannot disclose information regarding your medical condition, treatment plans, or test outcomes to anyone except you, the patient (or a responsible adult in the case of a minor), without your permission. If you choose, you can give us permission to leave information regarding tests and results with another person such as a spouse, significant other, or friend, if we are unable to reach you. Please provide the name and relation of that person here:

Name______________________ Relationship______________ Phone______________________

How can we contact you? (Please check all that apply): ☐Home Phone ☐Cell Phone ☐Work Phone ☐Voicemail

I understand and agree that if I have NOT heard from this office within 2 weeks of ANY testing/pathology, it is my responsibility to call NVSA and obtain the results. ______________________ (Initials)

IN CASE OF EMERGENCY NOTIFICATION

In case of an emergency, please notify:

Name______________________________________ Relationship______________________

Home/Cell Phone___(______)______________________ Work Phone____(______)______________________

BENEFIT ASSIGNMENT/ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby authorize the staff of North Valley Surgical Associates, P.C. (NVSA) to provide such medical services, either regular or emergency, as may be determined by my physician to be in my best interest (or the best interests of my dependent if I am signing as parent or guardian).

I authorize payment of medical benefits to NVSA. I agree that all charges for medical services rendered that are not directly paid by my insurance will be my responsibility. I hereby authorize NVSA to release the necessary information regarding me to my health plan in order to complete and process my insurance claims.

I hereby acknowledge that I have been presented with a copy of the North Valley Surgical Associates' NOTICE OF PRIVACY PRACTICES.

______________________________________ ______________________

Patient/Responsible Party Date

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FINANCIAL/INSURANCE

Patient Name____ Date________________

PRIMARY INSURANCE

Patient's relationship to policy holder: ☐Self ☐Spouse ☐Parent ☐Child ☐Other______________________

Policy Holder's Name____

Policy Holder's DOB______________________________ SSN__________________________

Employer____

Policy #______________________________ Group #______________________________

Plan Name____

Plan Address____

City__________________________ State______________ Zip Code________________

Phone___ __(______)___ ____

SECONDARY INSURANCE

Patient's relationship to policy holder: ☐Self ☐Spouse ☐Parent ☐Child ☐Other______________________

Policy Holder's Name____

Policy Holder's DOB______________________________ SSN__________________________

Employer____

Policy #______________________________ Group #______________________________

Plan Name____

Plan Address____

City__________________________ State______________ Zip Code________________

Phone___ __(______)___ ____

COMPLETE IF RESPONSIBLE PARTY IS OTHER THAN PATIENT/SELF

Name of Responsible Party______________________

Address______________________________

City____________ State________ Zip Code__________

Home Phone____(______)______________________

Work Phone____(______)______________________

Date of Birth__________ SSN________________

Relationship to Patient______________________

Employer______________________________

Address______________________________

City____________ State________ Zip Code__________

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MEDICAL AND SURGICAL HISTORY

Name: ____ Gender__________ Date of Birth: _____________________________

Reason for Visit: ____

MEDICAL HISTORY: (include medical conditions and problems, illnesses) (☐check if additional history on separate sheet of paper)

Medical Problem	Month/Year

Do you have sleep apnea? ☐Yes ☐No Do you use a CPAP Mask? ☐Yes ☐No

Can you take a flight of stairs without becoming short of breath? ☐Yes ☐No

OPERATION HISTORY: include all operations/procedures and month/year (☐check if additional info on separate sheet of paper)

Operation	Month/Year	City/State

CURRENT MEDICATIONS: (☐check if additional medications on separate sheet of paper)

Name	Dose	Frequency	Reason for Use

Have you taken steroids in the last 12 months? ☐Yes ☐No When? How given?____

Do you take an aspirin or a baby aspirin regularly? ☐Yes ☐No Date of last dose?____

Do you take herbal supplements? ☐Yes ☐No Which supplements?____

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MEDICAL AND SURGICAL HISTORY (Page 2)

Name: ____

ALLERGIES TO MEDICATIONS: (☐check if additional allergies on separate sheet of paper)

Medication	Type of Reaction	Date of Reaction
______________________	______________________	______________
______________________	______________________	______________
______________________	______________________	______________
______________________	______________________	______________
______________________	______________________	______________

Do you react to latex? ☐Yes ☐No

Do you react to IV dye? ☐Yes ☐No

SOCIAL HISTORY:

Have you ever used tobacco or nicotine? ☐Yes ☐No Type of tobacco: ☐Cigarettes ☐Pipe ☐Cigars ☐Smokeless

How many years?________________ Packs per day__________________ Approximate date of last quit attempt_____________________

Are you using tobacco currently?__________________________________ Would you like information on quitting? ☐Yes ☐No

Do you drink alcohol? ☐Never ☐Rare ☐Weekly ☐Daily If daily, number of drinks per day:______ If quit, when?________

Drug Use: Substance(s) used? ____

Frequency of Use (daily, weekly, rare):_________________ Quit (when?)____________

FAMILY HISTORY:

	Age	Disease/Condition	If deceased, cause of death?
FATHER	_______	____	_________________
MOTHER	_______	____	_________________
SIBLINGS	_______	____	_________________
	_______	____	_________________
SPOUSE	_______	____	_________________
CHILDREN	_______	____	_________________

Any family history of bleeding or blood clotting problems? ☐Yes ☐No
Any family history of anesthesia reactions or problems? ☐Yes ☐No

OFFICE USE ONLY

Date Reviewed:__________________________ Signature____

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REVIEW OF SYSTEMS

NAME______________________________DOB____________________ TODAY'S DATE__________________

	YES	NO
CONSTITUTIONAL		
Generally good health lately?		
Recent weight change		
Decreased appetite		
Fevers/night sweats		
Fatigue/weakness or low energy		
Headaches		
Prior Anesthesia problems?		
Regular exercise program?		
EYES		
Change in vision		
Any eye disease or injury		
Glasses/contact lenses		
EARS/NOSE/THROAT/MOUTH		
Difficulty hearing/ringing in ears		
Problems with teeth/gums/bloody nose		
Difficulty swallowing		
BREAST		
Breast lump		
Breast pain		
Nipple discharge		
CARDIOVASCULAR		
Heart Trouble		
Chest pain or angina pectoris		
Palpitations		
Shortness of breath when walking or lying flat		
Swelling of feet, ankles, or hands		
High blood pressure		
RESPIRATORY		
Cough/wheeze		
Difficulty breathing		
Sleep apnea		
GASTROINTESTINAL		
Loss of appetite		
Change in bowel movements		
Nausea or vomiting		
Frequent diarrhea		
Painful bowel movements		
Constipation		
Rectal bleeding or blood in stool		
Abdominal pain		
Ulcer (stomach)		

	YES	NO
GENITOURINARY		
Kidney disease		
Difficulty starting to urinate		
Frequent urination at night		
INTEGUMENT		
Mole change		
Rash and/or itching		
Change in skin color		
Change in hair or nails		
Varicose veins		
NEUROLOGICAL		
Headaches		
Dizziness/light-headedness		
Numbness		
Memory loss		
Loss of coordination		
Lose balance easily		
MUSCULOSKELETAL		
Muscle or joint pain		
Need cane/walker/wheelchair/aide to walk		
ENDOCRINE		
Glandular or hormone problem		
Thyroid disease		
Diabetes		
Use insulin for diabetes		
Excessive thirst or urination		
PSYCHIATRIC		
Memory loss or confusion		
Insomnia		
BLOOD/LYMPHATICS		
Slow healing after cuts		
Bleeding or bruising tendency, bleeding gums		
Anemia		
Blood clots too easily		
Blood transfusion		
Enlargened glands/lymph nodes		
ALLERGY/IMMUNOLOGY		
HIV		
Hepatitis		
Allergy to penicillin		
Bad reaction to morphine or other narcotics		
Bad reaction to other drugs/medications		

For Physician Use Only – Please do not write in this box

Signature______________________________________ Date of Review______________________

Updated/Review Date