**Premier Surgery Center**
2222 East Street, Suite 200
Concord, CA 94520

Phone: (925) 691-5000
Fax: (925) 691-5018

| Date: | Arrival Time: | Physician: |
|---|---|---|
| | | |

## PATIENT INFORMATION

| First name: | MI | Last Name: | Suffix:(Jr, etc) | Maiden Name |
|---|---|---|---|---|
| | | | | |

| Mailing Address: | City: | State: | Zip: |
|---|---|---|---|
| | | | |

| Home Phone: ( ) | Cell Phone: ( ) | Work/Alt Phone: ( ) |
|---|---|---|
| | | |

| Date of Birth: | Patient Social Security # | Sex: ☐ Male ☐ Female |
|---|---|---|
| | | |

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Decline to Answer

| Patient's Employer: | Occupation: | Employer Address: |
|---|---|---|
| | | |

| ☆ **Emergency Contact:** | **Phone Number:** | **Relationship:** |
|---|---|---|
| | | |

## FINANCIALLY RESPONSIBLE PARTY (if other than patient) **Relationship to Patient:** _____

| First Name | Middle Name/Initial | Last Name | Suffix |
|---|---|---|---|
| | | | |

| Mailing Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

## INSURANCE INFORMATION: *Please complete the following, and bring your insurance card(s) for copying*

**Primary Insurance Carrier**:

| Subscriber's Name: | Subscriber's Date of Birth | Social Security Number |
|---|---|---|
| | | |

| ID# | Group# |
|---|---|
| | |

| Insurance Address: | Insurance Phone# |
|---|---|
| | |

**Secondary Insurance Carrier**:

| Subscriber's Name: | Subscriber's Date of Birth | Social Security Number |
|---|---|---|
| | | |

| ID# | Group# |
|---|---|
| | |

| Insurance Address: | Insurance Phone# |
|---|---|
| | |

| **Workers Compensation: Carrier**: | Claim# | Date of Injury |
|---|---|---|
| | | |

| Adjuster Name: | Adjuster Phone Number |
|---|---|
| | |

The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, the surgery center may disclose portions of the patient's record including his/her medical records to any person or corporation which is or may be liable, for all or any portion of the surgery center's charge, including but not limited to insurance companies, health care service plans, worker's compensation carriers, the Social Security Administration or its intermediaries. Special permission is needed to release this information where the patient is being treated for alcohol or drug abuse. The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the surgery center and/or anesthesia consultant, x-ray consultant (Surgical Imaging Services Inc.), Contra Costa County Group, IPG, and any insurance benefits otherwise payable to or on behalf of the undersigned for these outpatient services, including emergency services if rendered, at a rate not to exceed the surgery center's charges. It is also understood that a separate bill may be received for services provided by any anesthesia, x-ray, pathology, or other outside consultant providing services. It is agreed that payment to the surgery center, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this agreement. It is also understood that all copayments and deductibles are due at the time of service.

| Date: | Signature of Patient / Responsible Party: |
|---|---|
| | |

Premier Surgery Center

**Primary Care Doctor:** _____

# PATIENT QUESTIONNAIRE

Please complete front and back of form

Name: _____ Age: _____ Height: _____ Weight: _____

**HAVE YOU HAD ANY OF THE FOLLOWING:** *Please explain any "yes" answers below (include dates, if known)*

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Anemia, blood disorder | ☐ | ☐ | GERD, heartburn, hiatal hernia | ☐ | ☐ | Pacemaker, AICD |
| ☐ | ☐ | Anxiety | ☐ | ☐ | Hay fever, sinus problems | ☐ | ☐ | Psychiatric, emotional or psychological problems |
| ☐ | ☐ | Arthritis | | | | | | |
| ☐ | ☐ | Asthma | ☐ | ☐ | Heart disease(s) | ☐ | ☐ | Recreational Drug Use |
| ☐ | ☐ | Back and/or Neck problems | ☐ | ☐ | Hepatitis | ☐ | ☐ | Seizures |
| ☐ | ☐ | Bleeding disorder, Blood Clots | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Sleep apnea, heavy snoring |
| ☐ | ☐ | Blood Transfusion | ☐ | ☐ | HIV/AIDS | ☐ | ☐ | Stomach or intestinal problems |
| ☐ | ☐ | Bronchitis or Pneumonia within last month | ☐ | ☐ | Kidney Disease | ☐ | ☐ | Stroke, TIA |
| | | | ☐ | ☐ | Liver disease | ☐ | ☐ | OTHER: _____ |
| ☐ | ☐ | Cold or Flu within last month | ☐ | ☐ | Lung disease, COPD | ☐ | ☐ | _____ |
| ☐ | ☐ | Cancer | ☐ | ☐ | Motion sickness | | | |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Nerve or neurological disease | | | |

_____

_____

**Please list any previous surgery you have had:**

1.) _____ Complications? Y N
2.) _____ Complications? Y N
3.) _____ Complications? Y N
4.) _____ Complications? Y N
5.) _____ Complications? Y N
6.) _____ Complications? Y N

**Do you have a family history of anesthesia complications?** ☐ Yes ☐ No *If yes, what kind*: _____

**Have you taken any aspirin containing / blood thinning products in the last two weeks?** ☐ Yes ☐ No

If so, what and when? _____

Do you smoke? ☐ Yes ☐ No If yes, how much per day? _____ If former smoker, when did you quit? _____

Do you drink alcoholic beverages? ☐ Yes ☐ No Do you wear contacts? ☐ Yes ☐ No

Do you wear dentures or bridges? ☐ Yes ☐ No Metal in your body? (joint replacement, pins, etc) ☐ Yes ☐ No

**WOMEN ONLY:** When was your last menstrual period? _____ Is there any chance you may be pregnant? Y N

Any recent Pregnancy ☐ Yes ☐ No Are you currently breastfeeding? ☐ Yes ☐ No

*** I last ate solid food at (time) _____** *** I last drank liquids at (time) _____**

I understand that driving a motorized vehicle less than 24 hours after sedation or anesthesia is **prohibited.** I will notify my physician **IMMEDIATELY** if any unusual bleeding, breathing problems or acute pain occurs after my discharge. I understand that if a condition arises during my admission, and a physician feels that admission to a hospital is best for my recovery, he/she may transfer me to a hospital for further care. In such event, I authorize the Center to release copies of my record to the acute care facility. I have left all valuables at home or in the care of others and hereby release the Center from responsibility for same.

**Signature**: _____ **Date**: _____

## *SIDE 1 of 2*

***Please Turn Over and Complete Reverse Side of This Form***

**Allergies to Medication:** ☐ *I have NO KNOWN DRUG ALLERGIES*

| I am Allergic To: | REACTION: (What happens when you take/come in contact with this medication?) |
|---|---|
| 1.) | ☐RASH ☐NAUSEA ☐STOMACH UPSET ☐OTHER: _____ |
| 2.) | ☐RASH ☐NAUSEA ☐STOMACH UPSET ☐OTHER: _____ |
| 3.) | ☐RASH ☐NAUSEA ☐STOMACH UPSET ☐OTHER: _____ |
| 4.) | ☐RASH ☐NAUSEA ☐STOMACH UPSET ☐OTHER: _____ |
| 5.) | ☐RASH ☐NAUSEA ☐STOMACH UPSET ☐OTHER: _____ |

☆ **LATEX ALLERGY?** ☐ Yes ☐No Rubber/Adhesive Sensitive? ☐ Yes ☐No
If yes, please specify? _____

## Current Medications: ☐ *I do not take any medications*

Please list all current medications you are taking, including prescription, non-prescription, and/or herbal supplements.

| Medication Name: | Dosage: | Times taken per day | Last Taken: |
|---|---|---|---|
| 1.) | | | |
| 2.) | | | |
| 3.) | | | |
| 4.) | | | |
| 5.) | | | |
| 6.) | | | |
| 7.) | | | |
| 8.) | | | |
| 9.) | | | |
| 10.) | | | |
| 11.) | | | |
| 12.) | | | |
| 13.) | | | |
| 14.) | | | |
| 15.) | | | |

**Medication information source:** ☐Patient ☐Family Member ☐Other: _____

Signature of Nurse reviewing medication on date of surgery: _____

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| ** TO BE COMPLETED BY PACU RN: ** PRESCRIPTIONS GIVEN AT DISCHARGE: | | | | |
|---|---|---|---|---|
| **Medication Name:** | **Dosage:** | **Times To Be Taken Per Day** | **For How long?** | |
| 1.) | | | | |
| 2.) | | | | |

## Medications reviewed at discharge*: _____

*** YAG/LASER procedures – Signature NOT APPLICABLE *** **RN signature**

***SIDE 2 of 2***