SURGERY SOUTH, LLC

985 9TH Ave. SW, Suite 507, Bessemer, AL 35022
Dr John Issis -- Dr Justin Moellinger -- Dr Matthew Reed
General, Thoracic & Minimally Invasive Surgery, Board Certified
(205) 481-7485.....fax (205) 481-7494

PATIENT INFORMATION PACKET

You have been referred to our office for an appointment.

We ask that you **fill out this information packet COMPLETELY** and bring it with you at the time of your appointment.

Also please bring the following items:

(1) **Driver's License and Insurance Cards**.....IF you are self-pay the office fee is **$55.00** and due at the time of your visit.
(2) **Co-payment for a SPECIALIST** if required by your insurance company. We accept checks, debit/credit cards, and cash. If paying with cash please bring the correct amount. Please contact your insurance company for your co-pay amount if unknown.
(3) **Your insurance may require a REFERRAL from your primary care**
(4) **physician**. If so, please make sure that the referral has been faxed to our office or you have the referral with you when you arrive for your appointment. Failure to do so may result in delaying your appointment of possibly rescheduling it for another day.
(5) **Any test or previous medical records** from other physicians or facilities relating to your current problem.
(6) A **complete LIST** of all your medications with dosage.

Please have all of the above information ready for the receptionist when you arrive at the office. Also we will be taking a photo of you for your chart for identification purposes.

We look forward to your visit !

SURGERY SOUTH, LLC

John O. Issis, M.D. Justin Moellinger, M.D. Matthew Reed, M.D.

DATE: _____

SS#: _____ - _____ - _____ **GENDER:** ☐ Female ☐ Male **AGE:** _____

PATIENT'S NAME: _____
LAST FIRST MIDDLE

Mailing Address: _____
P.O. BOX / STREET CITY STATE ZIP

Date of Birth: ____ / ____ / ____ **Home Phone:** (____) _____ **Cell Phone:** (____) _____
MM DD YY

Cell Carrier: _____ **Cell Phone for text messages if different:** (____) _____

E-MAIL ADDRESS: _____

RACE: ☐ Black ☐ Hispanic ☐ White ☐ Other

PRIMARY LANGUAGE: ☐ English ☐ Spanish ☐ Other _____

EMPLOYMENT INFORMATION

Patient's Employer: _____ **Occupation:** _____

Work Phone: (____) _____ **Is it okay to call you at work?** ☐ Yes ☐ No

MARITAL STATUS

☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Spouse: _____ **Age:** _____ **Date of Birth:** __/__/__
LAST FIRST MIDDLE MM DD YY

Cell Phone: _____ **Spouse's Social Security #:** ___ - ___ - ____

Spouse's Employer: _____ **Occupation:** _____

Work Phone: (____) _____

INSURANCE INFORMATION

Primary Ins.: _____ **Secondary Ins.:** _____

Policy Holder: _____ **Policy Holder:** _____

Contract/Policy #: _____ **Contract/Policy #:** _____

Group #: _____ **Group #:** _____

EMERGENCY CONTACT

Person to contact in case of emergency: _____

Relation to patient: _____ **Phone #:** _____

Patient Name: _____ Date: _____

Primary Care/Family Physician: _____ Phone Number: _____

Pharmacy Name: _____ Phone Number: _____

MEDICAL HISTORY

- ☐ Acid Reflux/GERD
- ☐ Alcohol Addiction
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Atrial Fibrillation
- ☐ Blood Clot
- ☐ Chest Pain
- ☐ Chronic Pain
- ☐ Cancer – Type: _____ Year: _____
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Fibromyalgia
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Pulmonary Disease
- ☐ Rectal Bleeding
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ TIA
- ☐ Other: _____

Have you ever seen a cardiologist? ☐ NO ☐ YES, If yes, who? _____

REASON FOR TODAYS VISIT: _____

SOCIAL HISTORY

Do you smoke? ☐ No ☐ Yes: _____ Packs Per Day for _____ years. ☐ Former Smoker ☐ Never Smoker

Do you drink alcohol? ☐ No ☐ Yes, Type: _____ How often? _____

Do you use recreational drugs? ☐ No ☐ Yes, Type: _____ How often? _____

PAST SURGICAL HISTORY

1). _____ Year: _____
2). _____ Year: _____
3). _____ Year: _____
4). _____ Year: _____
5). _____ Year: _____
6). _____ Year: _____

CURRENT MEDICATIONS

(*Please* provide name, milligram, quantity and when you take your medication)

1). _____
2). _____
3). _____
4). _____
5). _____
6). _____

Do you take *Aspirin* every day? ☐ No ☐ Yes, Prescribed by: _____

Do you take a *blood thinner*? ☐ No ☐ Yes, Prescribed by: _____

DRUG ALLERGIES

1). _____
2). _____
3). _____
4). _____
5). _____
6). _____

FAMILY MEDICAL HISTORY

	Father Living? ☐ Yes ☐ No	Mother Living? ☐ Yes ☐ No	Brother Living? ☐ Yes ☐ No	Sister Living? ☐ Yes ☐ No
Bleeding/Clotting Disorder				
Breast Cancer				
COPD				
Diabetes				
Heart Attack				
Heart Disease				
High Blood Pressure				
Mental Illness				
Other Cancer – Type:				
Stroke/TIA				

ALL PATIENTS WITH INSURANCE

I request that payment of the authorized benefits be made on my behalf to ***SURGERY SOUTH, L.L.C.***, for any services furnished to me. I authorize any holder of medical information about me to release to the above listed insurance companies and their agents any information needed to determine these benefits payable for related services.

Patient Signature: X_____ **Date:** _____

The patient and/or Responsible Party acknowledge, understand and agree that they are financially responsible for ***SURGERY SOUTH, L.L.C.***, even though there may be insurance or other third-party coverage, and agree that failure to make payment when requested is the basis for legal action, and agree to pay any and all costs of collection, including a reasonable attorney's fee.

Patient Signature: X _____ **Date:** _____

Responsible Party Signature: _____ **Date:** _____

I authorize ***SURGERY SOUTH, L.L.C.***, and its employees to speak with the following person(s) concerning my health care:

Name	Relationship	Phone Number

May we leave information on your answering machine at home? ☐ **Yes** ☐ **No**

May we leave information on your voicemail at work? ☐ **Yes** ☐ **No**

May we leave information on your cell phone? ☐ **Yes** ☐ **No**

Patient Initials: X_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of ***SURGERY SOUTH, L.L.C.'s*** Notice of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I also understand that if I request any restriction(s) concerning the use of my personal medical information, that the Practice may not be able to fulfill my request and that I will be notified if my request is denied. I understand that I may revoke the authorization at any time by notifying ***SURGERY SOUTH, L.L.C.*** in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation. I understand that this authorization is valid for twelve calendar months from the date of signature below unless otherwise specified. My signature below is acknowledgement that by request I will receive a copy of the ***SURGERY SOUTH, L.L.C.*** Privacy Notice and that I agree to the conditions stated in this notice:

Patient Signature: X_____ **Date:** _____

If not signed by the patient, please indicate relationship to patient.

Relationship: _____ **Witness:** _____

SURGERY SOUTH, LLC

John O. Issis, M.D. *Justin Moellinger, M.D.* *Matthew Reed, M.D.*

985 9th Ave. SW, Suite 507
Bessemer AL 35022
Phone: (205)481-7485
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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize _____ to release my entire
(DO NOT *write above this line. We will complete as needed*)
medical record / information (past and present) to Surgery South, L.L.C.

Additional Information:

_____

_____

_____

_____

_____

Patient's Name: _____

Patient's Birthdate: _____

Last 4 digits of patient's SS#: _____

Patient's Signature: X_____ **Date:** _____

Please fax the above requested records to (205)481-7494.