Dear _____,

This letter is to remind you of your appointment scheduled on _____. Please notify us if you will not be able to keep this appointment.

- Please read and print for your records the Policy Information brochure (located in the forms section of our website).
- Complete the enclosed information sheets and bring them with you to your appointment. If you do not have the forms filled out, you must arrive 30 minutes prior to your appointment. If you are unable to complete the forms in advance, you must bring someone with you to assist you in completing the forms.
- Failure to complete the forms in advance could result in delay and possible rescheduling of your appointment.
- If you have completed your paperwork arrive for your appointment 15 minutes early to allow for registration.
- Please be prepared to pay your co-pay at check in. If your insurance does not have a co-pay, but instead requires you to meet a deductible and / or pay a coinsurance percentage, we require a $50 deposit at **each** visit.
- Please bring your insurance cards and a picture ID
- Please bring a list of all of your medications, including over-the-counter drugs such as Tylenol, Advil, and any vitamins and supplements.
- Please bring your calendar with you in case future appointments are scheduled.

We will be happy to answer any questions you may have during your visit or by phone.

Sincerely,

Staff of Shenandoah Valley Surgical Associates

Shenandoah Valley Surgical Associates
William L. Faulkenberry M.D., F.A.C.S. ▪ William G. Thompson M.D., F.A.C.S. ▪ Charles D. Goff M.D., F.A.C.S.
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Shenandoah Valley Surgical Associates

Last Name	First	Middle/Maiden	Date of Birth:	
Mailing Address:		City:	State:	Zip Code:
Home Phone:		Work Phone:	Cell Phone:	
Social Security Number:		Family Doctor:	Referring Doctor:	
Gender: _____	Race: ❑ White ❑ African-American ❑ Asian ❑ Other: _____		Ethnicity: ❑ Hispanic ❑ Non-Hispanic	

Preferred Pharmacy: _____ Location: _____

Do you have an advance directive? ❑ Yes (Please make sure to provide our office with a copy)

❑ No (Would you like information regarding creating an advance directive ❑ Yes ❑ No)

PATIENT PORTAL

We have a full featured website for patient access! View medical information, results, ask questions, and receive appointment reminders.

_____ ❑ I do not have an email address ❑ I do not wish to share my email address

Email Address

We now have the ability to send appointment reminders by email. How would you prefer reminders? ❑ Email ❑ Phone

INSURANCE INFORMATION

Your insurance card(s) must be presented for us to copy. **Complete the information below if you are not the policy holder.**

Subscriber Name | Relationship | Subscriber Date of Birth | Subscriber Social Security Number

Subscriber Mailing Address | City | State | Zip Code

EMPLOYER INFORMATION

Employer Name | Employer Phone

Employer Street Address | City | State | Zip Code

EMERGENCY CONTACT INFORMATION

Emergency Contact Name | Emergency Contact Phone | Relationship

Emergency Contact Street Address | City | State | Zip Code

Do you give permission for our office to discuss Protected Health Information with this contact: ❑ Yes ❑ No

PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION

I hereby give my permission to the person(s) listed below to receive information about my medical care (Ex: Spouse, Relative, etc):

Name | Phone | Relationship

Name | Phone | Relationship

WITH MY SIGNATURE BELOW:

1. **By initialing below**, I acknowledge that I have received a copy, have read, and understand the Policy Information brochure dated 04/01/2016 and containing:
   a. _____ The HIPAA Notice of Privacy Practices **and** The Financial and Appointment Information Policy
      Initials
2. I understand SVSA has the right to change the above policies and I have the right to request a current copy at any time.
3. I authorize the release of any information requested by insurance companies or liable third parties and I assign any insurance or injury benefits to Shenandoah Valley Surgical Associates, Inc. I guarantee payment of all charges incurred to the account of the above named patient.

Signature of Patient or Legal Guardian | Date

Printed Name of Patient or Legal Guardian | Relationship (if not self)

Name: _____
Date of Birth: _____
Date of Visit: _____

Medical History

(Please color in the bubble of your answers)

Current Symptoms: Are you **CURRENTLY** experiencing any of the following symptoms:

Yes	No	Condition	Yes	No	Condition
❍	❍	Fever	❍	❍	Burning With Urination
❍	❍	Chills	❍	❍	Pass Blood With Urinating
❍	❍	Weight Loss	❍	❍	Temporary Slurred Speech
❍	❍	Weight Gain	❍	❍	Arm Or Leg Paralysis
❍	❍	Vision Loss	❍	❍	Abnormal Rash
❍	❍	Double Vision	❍	❍	New Skin Lesion
❍	❍	Hearing Loss	❍	❍	Chest Pain
❍	❍	Swallowing Problems	❍	❍	Pain In Legs When Walking
❍	❍	Shortness Of Breath	❍	❍	Nausea/Vomiting
❍	❍	Wheezing	❍	❍	Blood In Stool
❍	❍	Heat Intolerance	❍	❍	Diarrhea
❍	❍	Cold Intolerance	❍	❍	Vomiting Blood
❍	❍	Bleeding Easily	❍	❍	Joint Pain
❍	❍	Leg Swelling	❍	❍	Back Pain

Preventative Medicine: Have you ever had the following?

1. Flu Vaccination? ❍ Yes – Date of most recent _____ ❍ No
2. Pneumonia Vaccination? ❍ Yes – Date of most recent _____ ❍ No
3. A colonoscopy? ❍ Yes – Date of most recent _____ ❍ No

Complete Reverse Side ➔

Current Medications: Please list **ALL** medications you are currently taking. Include the dose, how many times per day you take the medication and include all over the counter medication, vitamins and supplements.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you take an aspirin daily? ❍ No ❍ Yes: Strength and Frequency:_____

Medical History: Check **ALL** conditions you have ever been diagnosed with.

❍ Heart Disease ❍ Breast Cancer ❍ COPD ❍ Thyroid Disease
❍ High Blood Pressure ❍ Colon Cancer ❍ Asthma ❍ Other Cancer: _____
❍ Diabetes ❍ Skin Cancer ❍ Kidney Disease
Other Condition: _____

Medication Allergies: Please list **ANY** drug allergies that you have **AND** the **REACTION**.

_____ _____
_____ _____

Surgeries: List **ALL** previous surgeries **AND** the **DATE** the surgery was performed.

_____ _____
_____ _____
_____ _____

Family History: Check **ALL** conditions the family member has been diagnosed with.

Father: ❍ Alive ❍ Deceased: Cause _____		**Mother:** ❍ Alive ❍ Deceased: Cause _____	
❍ Breast Cancer	❍ Hypertension	❍ Breast Cancer	❍ Hypertension
❍ Colon Cancer	❍ Heart disease	❍ Colon Cancer	❍ Heart disease
❍ Cancer: _____	❍ Stroke	❍ Cancer: _____	❍ Stroke
❍ Diabetes	❍ Unknown	❍ Diabetes	❍ Unknown
Other: _____		Other: _____	

List any diseases that run in your family: _____

Social History:

Tobacco Use:

❍ Never Smoked
❍ Former Smoker:
For: ❍ < 1 month ❍ 1-3 months ❍ 3-6 months ❍ 6-12 months ❍ 1-5 years ❍ 5-10 years ❍ > 10 years
❍ Current Smoker:
❍ Every Day ❍ Some Days How many per day: ❍ 5 or less ❍ 6-10 ❍ 11-20 ❍ 21-30 ❍ 31 or more
How soon after waking do you smoke? ❍ Within 5 min. ❍ 6-30 min. ❍ 31-60 min. ❍ After 60 min.
Are you interested in quitting? ❍ Ready to quit ❍ Thinking about quitting ❍ Not ready to quit

Employment: ❍ Employed – Occupation _____ ❍ Retired ❍ Disabled ❍ Unemployed
Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Widowed ❍ Other: _____
Are you a Jehovah's Witness (or do you refuse blood products)? ❍ Yes ❍ No
Have you used drugs (other than for medical reasons) in the last year? ❍ Yes ❍ No
Do you drink alcohol? ❍ Yes ❍ No
How often: ❍ Never ❍ Monthly or less ❍ 2-4 times per month ❍ 2-3 times per week ❍ 4+ times per week
Typical Amount: ❍ 1-2 ❍ 3-4 ❍ 5-6 ❍ 7-9 ❍ 10+
Frequency of 6+ drinks in one occasion? : ❍ Never ❍ Less than monthly ❍ Monthly ❍ Weekly ❍ Daily

Medicare Secondary Payer Questionnaire

Instructions for Completing Form: This questionnaire helps identify other payers which may be primary to Medicare. Please answer each question in sequence and comply with any instructions that follow an answer. If the instructions direct you to go to another question, please go directly to that question. Please disregard any comments that are in brackets […].

Patient's Name: _____

Date of Birth: _____

1. Are you currently employed? ❒ Yes ❒No – Date of Retirement _____
   a. If you answered no, please skip to question 4
2. Do you currently have health insurance coverage provided by a present or former employer? ❒ Yes ❒No
   a. If answered no, skip to question 4
3. Does the employer that provides your coverage employ 20 or more employees? ❒ Yes ❒No
   a. [If YES - Group Health Plan is Primary]
4. Do you currently have health insurance coverage provided by your spouse's present or former employer? ❒ Yes ❒No
   a. If answered no, skip to question 6
5. Does the employer that provides your spouse's coverage employ 20 or more employees? ❒ Yes ❒No
   a. [If YES - Group Health Plan is Primary]
6. Was your illness/injury due to work-related accident/condition? ❒ Yes – Date of injury/illness_____ ❒No
   a. [Workers Comp is Primary Payer if answered yes]
7. Was your injury/illness related to a non-work related accident? ❒ Yes – Date of accident_____ ❒No
   a. What type of accident caused the illness/injury? ❒ Automobile ❒ Non-automobile
   b. [YES-Fault Insurer is Primary Payer for claims related to accident]
8. Are you entitled to Medicare based on disability? ❒ Yes ❒No
9. Are you receiving Black Lung Benefits? ❒ Yes – Date benefits began_____ ❒No
   a. [Black Lung benefits are Primary Payer for claims]
10. Have you received dialysis treatments for End Stage Renal Disease? ❒ Yes – Date dialysis began_____ ❒No
11. Are you within the 30 month coordination period for End Stage Renal Disease Medicare Benefits? ❒ Yes ❒No
12. Have you received a kidney transplant? ❒ Yes – Date of transplant_____ ❒No

Signature of Patient or Legal Guardian Date

Printed Name of Patient or Legal Guardian Relationship (if not self)

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