CRATER LAKE
SURGERY CENTER, ASC

Medical Intake Form

Patient Name: _____ Date: _____ DOB: _____ Procedure to be performed: _____	Do you have a driver today? Y/N Name: _____ Phone Number: _____
When is the last time you ate **solid food**? _____ When is the last time you had **clear liquids**? _____ Allergy to **Latex**? _____ Allergy to **Iodine**? _____ Are you taking **Blood Thinners**? Y/N Which Blood Thinner? _____ How many days did you stop taking this for? _____ Are you on antibiotics? _____ Are you **Diabetic**? Y/N IF yes: What was your **blood sugar** today? _____	Height: _____ Weight: _____ **Current Medications:** Please turn in list or update list provided for you. **Allergies** Please turn in list or update list provided for you. **Pain Level Today (If here for a pain procedure)** **From 0-10:** _____

Fall Risk Questions:	**(Circle Yes or No)**	
1. Any falls in last 6 months regardless of reason ?	YES	NO
2. Any leg weakness, impaired gait, use of assistive devices?	YES	NO
3. Any disorientation, confusion, dementia?	YES	NO
4. Beyond corrective lenses, is there any visual impairment?	YES	NO

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Patient Intake Form

Date: _____

Name (first): _____ M.I.: _____ Last: _____ DOB: _____

Male ⬭ Female ⬭ Address: _____ City:_____ State : _____ Zip: _____

Home Telephone: _____ Cell Phone: _____

Social Security Number: _____ Drivers Liscense Number: _____

Perfered Method of Contact: _____ Email: _____

May we contact you via email?: _____ May we leave a detailed message?: _____

Emergency Contact: _____ Relationship: _____

Phone Number: _____ Address: _____ City: _____

State: _____ Zip: _____

Primary Care Provider: _____

Preferred Pharmacy: _____

Insurance Information

Please provide insurance cards.

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Patient Partnership Form

Dear Patient,

Welcome to Crater Lake Surgery Center. We hope to provide you with the care and service that you expect and deserve. Achieving your best possible health requires a "partnership" between you and your doctor. As our "partner in health", We ask you to participate in your care in the following ways:

I will keep all follow up appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medications, and possibly have other treatments to offer.

If I must cancel or reschedule, I will do so 24 hours in advanced of my scheduled appointment

If I must cancel or reschedule my appointment with Crater Lake Surgery Center, I will do so 24 hours in advanced of my scheduled procedure to avoid a cancellation fee.

Thank you for your partnership. As our patient, you have a right to be informed about your health care. We invite you, at any time, to ask questions, seek explanations, report symptoms, or discuss concerns. If you need more information about your health or condition, please ask.

Initials ☐

Statement of Financial Responsibility-

I, the undersigned, understand that I am responsible for all medical and surgical charges incurred by myself or dependents. I authorize the release of any medical information necessary to process any claims that are processed on my behalf by the office of Crater Lake Surgery Center. I understand that my medical insurance contract is between my insurance company and myself and the failure of the insurance company to pay my claim doesn't absolve my financial responsibility to Crater Lake Surgery Center. I understand that I may be billed separately for Professional fees, and Anesthesiology fees. All court and attorney fees or fees associated with the collection of my account are my financial responsibility.

Initials ☐

Signature (Patient for Guardian): _____ Date: ____/_____/ _____

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Notice of Privacy Practices

I hereby acknowledge that I was given the opportunity to review Crater Lake Surgery Center's **Notice of Privacy Practices (HIPAA)**, and that I have the right to ask for a paper copy to take with me. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request an amended copy of, **Notice of Privacy Practices** at each visit.

Patient Name (printed): _____ DOB: _____

Due to HIPAA laws, we are unable to share your medical information without your consent. Below I authorize Crater Lake Surgery Center's staff and medical personnel to share my medical information with the person(s) listed below:

_____ _____
Name and phone number Relationship to patient

_____ _____
Name and phone number Relationship to patient

Initials ☐

By initialing this box, I hereby authorize Crater Lake Surgery Center to communicate with me regarding my personal health via email.

Initials ☐

Under certain circumstances, Crater Lake Surgery Center may need to obtain outside records such as labs, radiologic reports, and medication histories from other facilities in order to provide care. By signing below, I authorize outside facilities to release such records.

Signature (patient, parent, or guardian): _____ Date: _____/ _____/ _____