PRE-REGISTRATION Date _____ Surgeon _____

Primary Care Physician _____ Phone No. _____

PATIENT INFORMATION

Name _____
Last First Middle Maiden

Address _____
Street City State Zip

Township/Boro_____County _____

Age _____ Date of Birth _____
Month Day Year

Home Phone No._____ Social Security No. _____

Sex ____ M ____ F Marital Status ____ Single ____ Married ____ Widowed ____ Divorced ____ Separated

Ethnicity/Race _____ Religion _____ Church _____

Employer _____ Phone No._____

Address _____
Street City State Zip

Nearest Relative (spouse, parent, child, etc.) _____
Name Relationship

Address _____ Phone No. _____
Street City State Zip

Have you ever been a patient at Sewickley Valley Hospital? ____ Yes ____ No

If yes, please list date _____

If you remain overnight at the Hospital, do you wish clergy to visit? ____ Yes ____ No

PAYMENT INFORMATION

We will make copies of all insurance cards and information for your chart and hospital use

(Please provide additional information only if it differs from information already given)

Person providing your health insurance coverage _____

Relationship to patient _____ Self _____ Spouse _____ Parent _____ Other Date of Birth _____

Address _____

Phone No._____ Social Security No. _____

Please list all types of health insurance coverage (Other) _____

Primary Insurance _____ Secondary Insurance _____

YOUR SURGICAL HISTORY (*Please list **all** past surgeries*)

Type of Surgery Year Hospital

_____

_____

_____

_____

_____

_____

(Examples: heart bypass, appendectomy, gallbladder removal, knee replacement)

Patient Name_____

Height_____ Weight_____

Phone Number_____
(where you can be reached 2 days prior to surgery)

Please fill out completely.

This information is used by your Anesthesia Physician and the staff at HVHS to ensure you receive the best possible care.

Please list all the medications you take including prescription, over the counter, herbals, supplements and diet aids.

_____
_____
_____
_____

Do you have a **latex allergy?** _____ **IF SO, NOTIFY SURGEON'S OFFICE STAFF IMMEDIATELY.**
List your **medicine allergies** _____
Please list any personal or family history of **problems with anesthesia** _____
_____
Which blood thinners do you take? (Coumadin, Plavix, Aspirin)?_____ For What?_____

Please ***circle*** any of the conditions listed below for which you have been diagnosed, treated, tested or take medication. If you had any testing, **please list when, where and doctor performing.**

HEART
☐ N/A
High Blood Pressure — Angina or Chest Pains
Heart Murmur — Irregular Heart Beat or Arrhythmia
Heart Attack — Pacemaker or Automatic Implantable Cardiac Defibrillator
Heart Catheterization _____
Stress Test _____
Echocardiogram/Ultrasound of Heart _____
Open Heart Surgery _____
EKG _____

LUNGS
☐ N/A
Asthma Wheezing COPD Emphysema Sleep Apnea
Do you smoke now?_____ Packs per day?_____ How many years?_____
When did you quit?_____ Packs per day?_____ How many years?_____

STOMACH
☐ N/A
Reflux / Hiatal Hernia / Heartburn on regular basis
Do you take over the counter antacids?_____ How often?_____

ENDOCRINE
☐ N/A
Diabetes or "Sugar" Pituitary Problems
Thyroid Cancer — Overactive / Underactive Thyroid
Other_____

KIDNEY
☐ N/A
Dialysis Kidney Stones
Other Problems_____

BRAIN AND NERVOUS SYSTEM
☐ N/A
Stroke Passing Out Multiple Sclerosis
Parkinsons Myasthenia Gravis Mini Stroke/Transient Ischemic Attack
Seizures Alzheimers Tumor
Other Problems_____

LIVER
☐ N/A
Hepatitis Jaundice
Other Liver Disease_____

CANCER
☐ N/A
Where?_____
How Treated?_____
When was last treatment?_____

GENERAL
☐ N/A
Anemia Bleeding Problems Motion Sickness
Claustrophobia Anxiety _____

Place Patient Label Here

145806 (7/12)

Uniquely Connected. For life.℠
HERITAGE VALLEY HEALTH SYSTEM

HEALTH HISTORY ASSESSMENT

Surgical Associates of Sewickley/ Hope Bariatrics
General, Advanced Laparoscopic and Bariatric Surgery
111 Hazel Lane Edgeworth Square Suite 100
Sewickley, Pennsylvania 15143-1136

PHONE: (412) 741-8862 **FAX: (412) 741-2553**

Geoffrey H Wilcox, MD, FACS
Michael D Felix, MD, FACS

Patient Name _____
Birth Date _____
Phone _____

On July 6, 2001, the U.S. Government passed compliance regulations (HIPPA LAWS) that mandate all healthcare facilities protect health information and Inform consumers of the healthcare information practices of the facility. At This facility, we have always, and will continue to protect the privacy of your health information.

Your privacy is important to us. Please take a moment to provide us with the requested information. List person or persons to whom we may release your medical information to.

NAME	RELATIONSHIP	PHONE
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

PATIENT SIGNATURE _____ DATE _____

_____ YES IT IS OK TO LEAVE A MESSAGE ON MY MACHINE
_____ NO DO NOT LEAVE A MESSAGE ON MY MACHINE

FOR MEDICARE PATIENTS: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Surgical Associates of Sewickley/Hope Bariatrics for any services furnished to me by physician or supplier. I authorize any holder of medical information about me to release to the centers for Medicare Services and its agents any information needed to determine these benefits payable for related services.

FOR ALL OTHER INSURANCES: I hereby authorize the release of any medical information necessary to process the claim and request payment of insurance carrier benefits to the party who accepts payment. I further authorize payment directly to the provider of services rendered to me.

SIGNATURE_____

DATE_____