OZARK SURGICAL GROUP
GENERAL & VASCULAR SURGERY
901 Burnett Drive
MOUNTAIN HOME, ARKANSAS 72653
870-425-9120 OFFICE

CHART _____

PATIENT INFORMATION

Patient: _____

Date of Birth: _____ **Age:** _____

Social Security Number: _____

Sex: **Male** **Female** **Marital Status:** **S M W D**

Mailing Address: _____

Street Address: _____

City/State/Zip: _____

Home Phone: _____

Cell Phone: _____

Employer: _____

Phone Number: _____

OTHER INFORMATION

❑ **Spouse** ❑ **Parent** ❑ **Legal Guardian**

Name: _____

Date of Birth: _____

Social Security Number: _____

Cell Phone: _____

Employer: _____

Race

❑ American Indian or Alaska Native
❑ Asian
❑ Black or African American
❑ More Than One Race
❑ Native Hawaiian
❑ Other Pacific Islander
❑ Refuse to Report
❑ Undefined
❑ White

Ethnicity

❑ Hispanic or Latino
❑ Not Hispanic or Latino
❑ Refuse to Report
❑ Undefined

Who is your family doctor? _____ **Dr. Phone Number:** _____

Who referred you to us? _____ **Phone Number:** _____

If we cannot reach you, whom may we contact that will be able to give you a message?

Name: _____ Phone: _____ Relationship: _____

Do you have voice mail or an answering machine? ❑ Yes ❑ No Email: _____

If yes, do we have your permission to leave messages on it? ❑ Yes ❑ No

PRIMARY INSURANCE

1. _____
Primary Insurance Company

_____
Insurance Policy Number

_____
Group Number

_____
Name of Policy Holder

_____ _____
Policy Holder's SSN Policy Holder's Date of Birth

_____
Policy Holder's Employer

SECONDARY INSURANCE

2. _____
Secondary Insurance Company

_____
Insurance Policy Number

_____
Group Number

_____
Name of Policy Holder

_____ _____
Policy Holder's SSN Policy Holder's Date of Birth

_____
Policy Holder's Employer

I hereby authorize insurance carrier(s), including Medicare, to pay directly to Ozark Surgical Group. I understand that I am and will be responsible for all fees regardless of insurance coverage. I also authorize Ozark Surgical Group and its agent, to furnish information to my insurance carrier, CMS, my family physician and referring physician concerning my illness and/or treatment for their records or to determine benefits.

_____ _____
Date Signature of Patient *(Parent or Guardian if patient is minor)*

Please Complete Entire Form!

Check any of the following conditions which you have now or have ever had:

❑ High Blood Pressure	❑ Asthma	❑ Epilepsy	❑ Arthritis (type) _____
❑ Previous Transfusion	❑ Stroke	❑ Claustrophobia	❑ Cancer (type) _____
❑ Persistent Cough	❑ Heart Attack	❑ Hepatitis (circle) A B C	❑ Diabetes (how long) _____
❑ Kidney Disease	❑ Heart Disease	❑ STD	❑ Dialysis (how long) _____
❑ Bleeding Disorder	❑ Lung Disease	❑ HIV/AIDS	❑ Blood Clots (location) _____
❑ Anemia	❑ Thyroid Disorder	❑ Atrial Fibrillation (A-fib)	❑ No problems at all
❑ Acid Reflux (GERD)	❑ High Cholesterol		

ALLERGIES:

Please list all allergies to **MEDICINES OR MEDICAL PRODUCTS (SUCH AS X-RAY DYE OR LATEX) and manifestations (rash, itching, swelling, etc.)** If you have no allergies, please write "None" _____

_____

_____

_____

Indicate family members with contributing illnesses such as heart disease, cancer, stroke, vascular disease, etc.

Relationship	Disease	Present Age	Age at Death	No History
Father				
Mother				
Brother(s)				
Sister(s)				

Current Occupation _____ Previous Occupation _____

Tobacco Usage: Have you ever: Smoked ❑ Yes ❑ No Packs per day _____ How Long _____

If you have quit, when _____ Do you use smokeless tobacco ❑ Yes ❑ No

Alcohol Usage: Do you drink alcohol ❑ Yes ❑ No Type _____ How much _____ How Often _____

Drug Usage: Do you use illegal drugs? ❑ Yes ❑ No ❑Past Type _____

Do you abuse prescription pills? ❑ Yes ❑ No ❑Past Type _____

Patient Name (printed) _____ DOB _____

Patient Signature _____ Today's Date _____

Medications:

Please list all medications you take, including vitamins and supplements. If you take no medication, please write “None”.

	Medication	Strength	How Often Taken	What For
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Name of Pharmacy _____ City _____

Females: How many pregnancies have you had? _____ Live births?_____ Miscarriages? _____ Abortions? _____

Your age at first delivery? _____ Did you breast feed? _____

Have you had a mammogram within the last year? ❑ Yes ❑ No

List ANY and ALL past surgeries with dates and/or major medical problems (If no surgical history, please write “None”.)

_____

_____

_____

_____

Do you have: pacemaker/defibrillator ❑ Yes ❑ No Implants ❑ Yes ❑ No (type) _____

Metal in your body ❑ Yes ❑ No

Have you ever had a colonoscopy ❑ Yes ❑ No Date of last colonoscopy _____

Do you have chronic pain for which you receive monthly pain medication? ❑ Yes ❑ No

If yes, do you have a pain contract? ❑ Yes ❑ No With whom? _____

Patient Name (printed) _____ DOB _____

Patient Signature_____ Today's Date_____