

❖ BayChoice Surgeons

Patient Information

Name (First to Last)		Social Security Number - -		Marital Status S M D W		Age	Gender Male / Female	Birth Date / /
Address- Street name and number				Home Phone Number () -		Work Phone Number () -		
City/ State/ Zip Code				Cell/Pager Phone Number () -		Driver's License Number		
Employer Name/ Place of Employment		Employer's Address/ City/ State/ Zip Code				Occupation		
Emergency Contact- PLEASE GIVE: NAME, RELATIONSHIP, AND PHONE NUMBER OF PERSON <u>NOT</u> LIVING WITH YOU.							E-Mail Address	
Injured Area or Presenting Problem		Date of Injury or Indication of Problem		How did you hear about us or who were you referred by?				

THIS SECTION IS REQUIRED. PLEASE FILL OUT ALL INFORMATION ASKED. COMPLETE THIS SECTION WITH THE INSURED/ POLICYHOLDER'S INFORMATION, AND IF THE PATIENT IS UNDER 18 YEARS OLD.

Guarantor Information

Name		Social Security Number - -		Relationship of Patient to Responsible Party Spouse Child Other		Gender Male / Female	Birth Date / /
Address- Street number & name/ City/ State/ Zip Code						Home Phone Number () -	
Employer Name/ Place of Employment Employer's Address/ City/ State/ Zip Code				Work Phone Number () -		Occupation	

Insurance Information

PLEASE PRESENT YOUR INSURANCE CARD & PICTURE ID TO OUR RECEPTIONIST.

<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid			<input type="checkbox"/> Automobile Accident
ID Number:	ID Number:			Date: / /
<input type="checkbox"/> Insurance	ID Number:		Group Number	Policyholder or Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parental <input type="checkbox"/> Other:
Company Name:				
<input type="checkbox"/> Additional/ Secondary Insurance	ID Number:		Group Number	Policyholder or Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parental <input type="checkbox"/> Other:
Company Name:				

****Please fill out the information below ONLY if the policyholder/ insured is NOT you or the guarantor for your secondary insurance.**

Name		Social Security Number - -		Relationship of Patient to Responsible Party Spouse Child Other		Gender Male / Female	Birth Date / /
Address- Street number & name/ City/ State/ Zip Code						Home Phone Number () -	
Employer Name/ Place of Employment Employer's Address/ City/ State/ Zip Code				Work Phone Number () -		Occupation	

I request that payment of authorized insurance benefits be made on my behalf to the provider indicated above for any services furnished to me. I authorize that any holder of medical information about me or my dependant to be release to the insurance company. Any information needed to determine these benefits payable for related services for 90 days form the date below. A copy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not covered by said insurance. I hereby authorize the attending physician to instruct his Nurse and/ or Physician Assistant to assist him with certain aspects of my medical condition. I understand that the Nurse and/ or Physician Assistant is not a licensed physician and may not diagnose any illness, injury or medical condition except under the supervision and direction of a licensed physician. I understand that I may revoke this authorization at any time.

Patient/ Guarantor's Signature _____

Date: _____

Kenneth Hollis, M.D., FACS
 11914 Astoria Boulevard, Suite 125
 Houston, TX 77089
 Ph. 281-482-5300

Medical History

Women: Are you

Pregnant/Trying to get pregnant? Yes No

Taking Oral contraceptives? Yes No

Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Tylenol Latex Local Anesthetics Other

If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="checkbox"/> Yes <input type="checkbox"/> No	Easily Winded <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B or C <input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No
Anaphylaxis <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Angina <input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst <input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Gout <input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting Spells/Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough <input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No	Genital Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily <input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack/Failure <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No	Other: _____
Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No	
Congenital Heart Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pace Maker <input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No	
Cortisone Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Trouble/Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No	
Drug Addiction <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A <input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No	

Have you ever had any serious illness not listed above? Yes No

If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian

Date

Patient Name: _____

DOB: _____

Patient Past Medical History

I have no past medical history to report.

Please Check All That Apply:

	X	Note		X	Note
Skin			Infectious Disease		
Psoriasis			HIV +		
Skin Cancer			AIDS		
Hematologic			VRE		
Anemia			MRSA		
Blood Transfusion			Tuberculosis		
Hemophilia			Mental Health		
Von Willbrand Disease			Depression		

Past Surgical History

I have no past surgical history to report.

Allergies:

Head and Neck Surgery	X		Cardiovascular Procedures/Surgery	X	
Tonsillectomy			Stress Test-Treadmill or Chemical		
Nasal Surgery			Heart Catherization		
Sinus Surgery			Cardiac Angioplasty		
Surgery for Sleep Apnea			Cardiac Stents		
Thyroid Surgery			Cardiac Bypass Surgery		
Breast Surgery			Cardiac Valve Replacement		
Breast Biopsy		<input type="checkbox"/> Right <input type="checkbox"/> Left	Pacemaker		
Breast Lumpectomy		<input type="checkbox"/> Right <input type="checkbox"/> Left	Implantable Defibrillator		
Mastectomy		<input type="checkbox"/> Right <input type="checkbox"/> Left	Aortic Aneurysm Repair		
Breast Augmentation			Carotid Repair		<input type="checkbox"/> Right <input type="checkbox"/> Left
Breast Reconstruction		<input type="checkbox"/> Right <input type="checkbox"/> Left	Vascular Bypass		
Abdominal/ Colon Surgery			Gynecology/ Urology		
Appendectomy			Hysterectomy		
Gallbladder			Caesarean Section		
Hiatal Hernia/Reflux Surgery			Tubal Ligation		
Weight Loss Surgery			Ovary Removal		
Stomach Surgery for an ulcer			Bladder Suspension		
Surgery for adhesions			Laparoscopy		
Partial Colon Removal		<input type="checkbox"/> Tumor	Cystoscopy		
Hemorrhoid Surgery			Prostate Surgery		
Groin Hernia		<input type="checkbox"/> Right <input type="checkbox"/> Left	Kidney Stone Crushing- Lithotripsy		
Umbilical Hernia		<input type="checkbox"/> Right <input type="checkbox"/> Left	Kidney Removal		<input type="checkbox"/> Right <input type="checkbox"/> Left
Incisional Hernia					

Other Illnesses, Hospitalizations, or Operations (not listed above)

Place	Year	Illness, Injury, Operation	Doctor

