ATHENS THORACIC & VASCULAR SURGERY, P.C.

PATIENT INFORMATION

Date: _____/_____/20______

Name: ____

Address: ____

____

Telephone: **Home:** (_____)______________________ **Cell:** (_____)______________________________

Employer: ____

Address: ____

Telephone: Work:(_____)______________________

ALLERGIES:____

Date Of Birth:____

Social Security #:____

Marital Status:____

Spouse's Name:____

Spouse's Number:(_____)______________________

Spouse's Employer:____

EMERGENCY CONTACT:____

Phone Number: (_____)______________________

INSURANCE:Primary:____

Secondary:____

What Hospital Does Your Insurance Require For Treatment And/ Or Surgery:

Athens Regional Medical Center **Saint Mary's Hospital**

Referring Doctor: **Specialist:**____

Primary Care:____

Consent For Disclosure To Family Member And/ Or Personal Representative

Athens Thoracic &Vascular	Patients Name And Address:
Surgery, P.C.	______________________________
784 Prince Ave.	______________________________
Athens, GA 30606	______________________________

I have agreed to let certain individuals participate in the discussions and decisions related to my medical care. Therefore, I hereby give my permission for Athens Thoracic & Vascular Surgery, Dr. Maffei and his office staff to disclose my personal medical information to the following individual (s):

Name:______________________________ Relationship:______________________________

Name:______________________________ Relationship:______________________________

Name:______________________________ Relationship:______________________________

Conditions For Disclosure (check the item(s) that apply)

_____ The Practice may disclose my personal health information to the individual(s) above ONLY in my presence.

_____ The Practice may disclose my personal health information to the individual(s) above in discussions in my presence and when I am not physically present, including disclosures by telephone, facsimile, e-mail or regular mail.

_____ Other Conditions of Disclosure____

I understand that this consent is in effect until revoked by me by written notice to the practice.

Patient Signature ______________________________ Date:______________________________

Witnessed By ______________________________ Title:______________________________

Print Name of Witness ______________________________ Date:______________________________

PATIENT PERSONAL HISTORY

Confidential Record: Information contained here will not be released except when you have authorized us to do so. Please answer all the questions to the best of your knowledge. The information provided by you will be used by your doctor in his decisions regarding your care.

LastName:_________________________FirstName:____________________________Middle_____

Do you Have or Have you had: (Please circle yes or no. If **yes**, provide date of occurrence.)

No Yes ____ Cancer

HEAD / NECK
No Yes ____ Tonsillitis

NEURO
No Yes ____ Seizures
No Yes ____ Stroke
No Yes ____ Epilepsy
No Yes ____ Migraine
No Yes ____ Tremors

PULMONARY
No Yes ____ Tuberculosis
No Yes ____ Bronchitis
No Yes ____ Pneumonia
No Yes ____ Hay Fever
No Yes ____ Exposure to Asbestos
No Yes ____ Blood Clot in Lung

CV
No Yes ____ Heart Attack
No Yes ____ Heart Failure
No Yes ____ Rheumatic Fever
No Yes ____ Congenital Heart Problems
No Yes ____ High Blood Pressure

EDNOCRINE
No Yes ____ Thyroid Disease
No Yes ____ Diabetes

GI/ GU
No Yes ____ Hepatitis
No Yes ____ Gall Bladder Disease
No Yes ____ Stomach Ulcers
No Yes ____ Pancreatic Disease
No Yes ____ Kidney Disease
No Yes ____ Bladder Infection

Musculoskeletal
No Yes ____ Arthritis
No Yes ____ Poor Circulation
No Yes ____ Gout

DERM
No Yes ____ Psoriasis
No Yes ____Dermatitis
No Yes ____ Eczema

COAGULOPATHY
No Yes ____ Bleeding Tendency
No Yes ____ High Fever After Blood Transfusion
No Yes ____ Blood Clots

PSYCH
No Yes ____ Nervous Breakdown

Do you know of any blood relative that Has, or Has Had. (If **yes**, give relationship)

No Yes ____ Tuberculosis
No Yes ____ Seizures
No Yes ____ Stroke
No Yes ____ Cancer
No Yes ____ Epilepsy
No Yes ____ Diabetes
No Yes ____ Hepatitis
No Yes ____ Arthritis
No Yes ____ Migraine

No Yes ____ Hay Fever
No Yes ____ Gall Bladder Disease
No Yes ____ Thyroid Disease
No Yes ____ Asthma
No Yes ____ Heart Attack
No Yes ____ Heart Failure
No Yes ____ Stomach Ulcers
No Yes ____ Kidney Disease
No Yes ____ Rheumatic Heart Disease

No Yes ____ Congenital Heart Problems
No Yes ____ Bleeding Tendency
No Yes ____ High Blood Pressure
No Yes ____ Blood Clots
No Yes ____ Poor Circulation
No Yes ____ Nervous Breakdown
No Yes ____ Suicide

______________________________M.D. __________________
Physician's Sig. Date

REVIEWED BY T. PETERMAM (8/8/2012)

Name:______________________
D.O.B.______________________

Please List the Medications and Foods you are ALLERGIC to:

____
____
____
____

Please List ALL the Medications you are Currently Taking. Give Dosage and Frequency.
(List **ALL** Prescription, Non-Prescription and Herbal. For Example: **Aspirin 81 mg Once a Day)**

__________________________________ __________________________________
__________________________________ __________________________________
__________________________________ __________________________________
__________________________________ __________________________________
__________________________________ __________________________________
__________________________________ __________________________________
__________________________________ __________________________________
__________________________________ __________________________________
__________________________________ __________________________________
__________________________________ __________________________________

Which Pharmacy Do You Regularly Use?
Name_________________________________
Phone_________________________________
City _________________________________

Please List Previous Surgeries / Hospitalizations and Give Dates and Facility Name

____
____
____
____
____
____

Have You Ever Smoked? Yes No
How Much? ____________________
How Many Years? ________________

Do You Drink Alcohol? Yes No
How Much?______________________
How Often?______________________

Do You Use Illicit / Illegal Drugs? Yes No
What Drugs?____________________
How Often?_____________________

Are You Pregnant? Yes No
Do You Plan on becoming Pregnant? Yes No

_________________________**M.D.** _______________
Physician's Sig. **Date**

REVIEWED BY T. PETERMAM (8/8/2012)