

## PATIENT MEDICAL HISTORY

DATE \_\_\_\_\_

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_ LAST VISIT \_\_\_\_\_

**ALLERGIES** \_\_\_\_\_ WHY ARE YOU SEEING THE DOCTOR TODAY? \_\_\_\_\_

MEDICATIONS: 1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_  
5. \_\_\_\_\_ 6. \_\_\_\_\_

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HAVE YOU IN THE PAST OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING? (Check all that apply)

ANGINA      ARTHRITIS      ASTHMA      BRONCHITIS      THYROID DISEASE  
CANCER      DIABETES      EMPHYSEMA      FAINTING SPELLS  
HEART ATTACK      HEART MURMUR      HEART VALVE DISEASE      HIGH BLOOD PRESSURE  
KIDNEY DISE      LIVER DISEASE      PNEUMONIA      SHORTNESS/BREATH      STROKE

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DO YOU SMOKE? \_\_\_\_\_ PACKS PER DAY \_\_\_\_\_

LAST MENSTRUAL PERIOD (IF APPLICABLE) \_\_\_\_\_

DO YOU DRINK ALCOHOL? \_\_\_\_\_ HOW OFTEN? \_\_\_\_\_

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PREVIOUS SURGERY:      APPROXIMATE DATE:  
1. \_\_\_\_\_      \_\_\_\_\_  
2. \_\_\_\_\_      \_\_\_\_\_  
3. \_\_\_\_\_      \_\_\_\_\_

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FAMILY HISTORY (check all that apply)

ANGINA      ARTHRITIS      BREAST CANCER      CANCER  
DIABETES      EMPHYSEMA      FAINTING SPELLS      HEART ATTACK  
HEART MURMUR      HIGH BLOOD PRESSURE      KIDNEY DISEASE      LIVER DISEASE  
RHEUMATIC FEVER      SHORTNESS OF BREATH      STROKE      THYROID DISEASE

**SOUTH TOWNS SURGICAL ASSOCIATES**

310 Sterling Drive Suite 105

Orchard Park, NY 14127

716-675-7730

**PATIENT CONSENT FORM**

NYS law prohibits our medical office staff from speaking with any individual other than yourself regarding any of your medical health information. This includes information regarding your condition, medication, appointments or test results. **This is to protect your rights as a patient that your records are kept confidential.** Should you prefer that any person be able to discuss your medical chart/condition on your behalf, this form should be completed and signed with a witness signature.

I, \_\_\_\_\_,  
(patient name)

give South Towns Surgical Associates my permission to speak with

\_\_\_\_\_ regarding any of my health information,  
(person's name & relationship)

including but not limited to, test results, appointments, physician advice and treatment.

I have read and understand the above information.

\_\_\_\_\_  
(patient signature)

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(witness signature)

\_\_\_\_\_  
(date)

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I give South Towns Surgical Associates authorization to leave a message on my voice mail/answering machine regarding any of my health information.

\_\_\_\_\_  
(patient signature)

\_\_\_\_\_  
(date)

TO ALL OF OUR VALUED SOUTH TOWNS SURGICAL PATIENTS:

At South Towns Surgical we are doing our very best to keep up with the rapid changes to health care plans. To help us provide the quality of care that you have come to expect from us, we would like to make you aware of the patient policies that must be adhered to.

We are no longer able to bill you for your copayment. **Your co-pay/co-insurance must be paid before you are seen by your Provider or we will need to reschedule your appointment.** Due to policy provisions in your insurance contract with your insurance carrier and under terms of the federal anti-kickback laws, we are legally prohibited from writing off deductibles, co-payments and patient responsibility co-insurance as directed by your insurance carrier. This is a contractual obligation that we have with the local health care plans and by asking us to waive your copayment or not bill it to you, we are in direct violation of our agreement which could result in termination of our relationship with the health care plan.

Please do not put our Providers in an uncomfortable situation by asking them about your bills or payments. We have a Billing Office Staff that our Physicians have provided to work with you regarding your financial obligations to South Towns Surgical. It is ultimately your responsibility to understand your specific coverage that is provided under the health plan that you choose to enroll into.

Thank you for your cooperation.

The Doctors and Staff at South Towns Surgical Associates

\_\_\_\_\_ Date \_\_\_\_\_  
Name