

- Thomas L. Poulin, M.D., F.A.C.S.
- Charles E. Peterson, M.D., F.A.C.S.
- John W. Oren, M.D., F.A.C.S.
- Timothy W. Noveroske, M.D., F.A.C.S.
- Scott G. Thomas, M.D., F.A.C.S.

GENERAL & VASCULAR SURGERY, P.C.
 621 Memorial Drive, Suite 302
 South Bend, IN 46601

- George M. Brennan, M.D. (Elkhart)
- Michael C. Rotkis, M.D., F.A.C.S. (Elkhart)
- Edward P. Delle Donne, M.D., F.A.C.S., F.A.S.C.R.S.
- Jeffrey S. Borders, M.D.
- Mark A. Thompson, M.D.

PATIENT QUESTIONNAIRE

Referring Doctor _____ Family Doctor _____

Reason for today's visit _____ Date of onset _____

Have you ever seen any of the doctors in this practice before? Yes No Whom? _____ When? _____

Today's Date _____		<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate: _____	Age: _____	Marital Status: M S D W
Name: _____		(First)	(Middle)	(Last)	
Address: _____			City/State: _____	Zip: _____	
S.S. # _____		Home phone: _____		Cell Phone #: _____	
Patient's Employer: _____			Employer Address: _____		
City/State: _____		Zip: _____	Employer Phone #: _____		
Spouse's/Partner's Name: _____			Cell Phone #: _____		
Emergency contact Person: _____			Relationship: _____	Phone: _____	
Emergency contact Person: _____			Relationship: _____	Phone: _____	

PREVIOUS OPERATIONS/INJURIES: _____

MAJOR MEDICAL PROBLEMS: _____

MEDICATIONS/DOSAGES: _____

ALLERGIES: Are You Allergic to Latex? Yes No
 Medication/Dye Allergies _____ Other Allergies _____

PATIENT REVIEW OF SYSTEMS		Yes	No	Comment
Constitutional:	A. Recent weight change?	---	---	
	B. Weakness, fatigue or chills?	---	---	
Eyes:	A. Difficulty seeing?	---	---	
	B. Contact lenses?	---	---	
Cardiovascular:	A. Chest pain (heart pain, angina)?	---	---	
	B. Known heart rhythm problems?	---	---	
	C. Leaky heart valves?	---	---	
	D. Problems with circulation?	---	---	
	E. High or low blood pressure?	---	---	
Respiratory:	A. Chronic cough?	---	---	
	B. Shortness of breath with exertion (e.g. when you go up a flight of stairs)	---	---	
	C. Wheezing?	---	---	

Patient Name: _____

Date: _____

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PATIENT REVIEW OF SYSTEMS (cont.)

		Yes	No	Comment
G.I.:	A. Constipation?	___	___	
	B. History of jaundice?	___	___	
	C. Recent change in appetite?	___	___	
	D. Blood per rectum?	___	___	
	E. Frequent heartburn or indigestion?	___	___	
	F. Diarrhea?	___	___	
G.U.A.:	A. Frequent bladder infection?	___	___	
	B. Frequent nighttime urination?	___	___	
	C. Incontinence?	___	___	
M.S.:	A. Joint pain requiring medication?	___	___	
	B. Calf or leg pain with walking?	___	___	
	C. Arthritis?	___	___	
Skin:	A. Rashes?	___	___	
	B. Skin cancers?	___	___	
	C. Other major skin problems?	___	___	
Neuro:	A. TIAs or minor strokes?	___	___	
	B. Recent numbness or weakness?	___	___	
	C. History of seizures?	___	___	
Psych:	A. Depression?	___	___	
	B. Anxiety?	___	___	
	C. Other psychiatric problems?	___	___	
Endocrine:	A. History of high or low blood sugar?	___	___	
	B. Thyroid problems?	___	___	
Heme/Lymph:	A. Bleeding tendencies/bruising, or frequent nose bleeds?	___	___	
	B. Any history of anemia?	___	___	
	C. Do you have sickle cell disease?	___	___	
Breast:	A. Pain?	___	___	
	B. Discharge?	___	___	
	C. Other changes or abnormalities?	___	___	

FAMILY HISTORY (Blood relatives)

	Yes	No
A. Any family members with unusual reaction to anesthesia?	___	___
B. Any family members with colon, breast, ovarian, or prostate cancer? Circle which one (s).	___	___
C. Any immediate family members with heart disease?	___	___
D. Father? <input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age _____ Cause? _____	___	___
E. Mother? <input type="checkbox"/> Alive <input type="checkbox"/> Deceased Age _____ Cause? _____	___	___

SOCIAL HISTORY

	Yes	No	
A. Are you now or have you ever been a smoker?	___	___	Initial _____
B. How long have you been smoking? _____ How Much? _____	___	___	Date _____
C. Any history of drug abuse/addiction?	___	___	
D. How many alcoholic beverages per week? _____	___	___	

GYN History:		FEMALES ONLY	
A. Age at onset of menstrual cycle?	_____	D. Number of children?	_____
B. Age at onset of menopause?	_____	E. Date of last menstrual period?	_____
C. Age at first pregnancy?	_____	F. Are you pregnant now?	_____

**PLEASE BRING YOUR INSURANCE/MEDICARE CARD WITH YOU,
AS A COPY WILL BE MADE FOR YOUR RECORD**

We will assist you by filing a claim to your insurance carrier. Please carefully read and complete the following information.

Indicate the type of insurance plan to be billed for reimbursement of your current medical problems. Please complete the appropriate sections. **If you do not bring your insurance card(s) with you at the time of your visit, we will consider you to be a self-pay patient.**

PERSON RESPONSIBLE FOR BILL

Last name: _____ First name: _____ MI: _____ Relationship to patient: _____
Sex: M F Date of birth ____/____/____ SS# _____ Home phone: (____) _____
Address: _____ City, State, Zip: _____

INSURANCE INFORMATION

Primary insurance co. name: _____ Name of policy holder: _____
Policy holder's S.S.# _____ I.D.#: _____ Group#: _____
Policy holder employer: _____ Employer Address: _____
Employer phone: _____ Date of Birth: _____

Secondary insurance co. name: _____ Name of policy holder: _____
Policy holder's S.S.#: _____ I.D.#: _____ Group#: _____
Policy holder employer: _____ Employer Address: _____
Employer phone: _____ Date of Birth: _____

ACCIDENT INSURANCE INFORMATION

WORKERS COMPENSATION (if checked, complete the following):

Employer: _____ Date of onset: _____

Has employer been notified of the accident? Yes No Claim # _____

Employer's address: _____

City/State/Zip: _____

Contact Person: _____ Phone: _____

Carrier: _____

City/State/Zip: _____

Accident (other than Workers Compensation). Claim # _____

Accident related/liability claim (yours)? Yes No

Accident related/liability claim (somebody else's)? Yes No

If yes complete the following:

Carrier: _____

City/State/Zip: _____

**IF THIS IS AN AUTO ACCIDENT, WE WILL NEED TO HAVE AUTO INSURANCE
INFORMATION AS SOON AS POSSIBLE**

General & Vascular Surgery, PC

Financial Policy

We are committed to providing you with the best possible medical care. We are available to work with you if you have special financial needs. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

Our office participates in a variety of insurance plans. **It is your responsibility to:**

- Bring your insurance card and photo ID to every visit.
- Obtain the necessary physician referral or pay all office fees at the time of service or completion of services. NOTE: If the referral has not been obtained, you will be asked to sign an Insurance Referral Waiver.
- Remit payment for medical care not covered under your insurance (deductibles, copays, non-covered services, etc.) at time of service.
- Be prepared to pay your co-pay at each visit. Payment may be made by cash, check or credit card.
- All private pay fees will be collected at time of service.

If we do not participate in your insurance program, our office is happy to file the claim; however, payment in full is expected from you within 30 days.

For patients 17 years and younger, a parent or legal guardian must accompany them and sign below (exception: patients 17 years and younger declared emancipated minors). It is the parent or guardian's responsibility to bring the necessary referrals and insurance cards and also to make any payment due at time of service.

Our charges are determined by what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company's members services department (the number is on your insurance card).

Our practice firmly believes that a good physician/patient relationship is based upon understanding and communication. Questions about financial arrangements should be directed to the Central Billing Office. The office may be reached by dialing 574-251-2100.

Please sign below to indicate that you have read and agree to this Financial Policy.

I understand and agree to this Financial Policy.

Signature of Patient or Responsible Party

Date