

ABBEVILLE SURGICAL
 CHRISTOPHER CERALDI, MD F.A.C.S
 901 W. GREENWOOD ST SUITE 8B
 ABBEVILLE SC, 29620
 (864) 366-5345

IMPORTANT NOTICE
 Due to HIPPA requirement, this form **MUST** be filled out completely
 Please ask for help if you have questions about any field.
 We will be **UNABLE** to file insurance for incomplete forms.

PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last: _____

Social Security #: _____ - _____ - _____ Date of Birth: _____ Age: _____

Mailing Address: _____ City/ State: _____ Zip Code: _____

Home Phone : () _____ Cell Phone: () _____

Gender: _____ Race: _____ Marital Status: _____ Spouse Name: _____

Employment Status: Full Time Part Time Self Retired None Student Status: _____

Employer/School Name: _____ Work Phone#: _____

Employer Address: _____

Emergency Contact Information should not be someone living in the home with you:

Emergency Contact: _____ Phone _____

Family Physician: _____ Pharmacy Name: _____

HIPPA AUTHORIZATION ACCESS TO MEDICAL RECORDS

I authorize the following people to have access to my protective health information or medical information.

Please list the names and the relationship to you:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

INSURANCE INFORMATION

	Primary	Secondary	Tertiary
Subscriber(legal name)			
Telephone:			
Relation to pt:			
DOB:			
Social Security #:			
Employer:			
Address & Phone #:			
Insurance Company:			
Phone #:			
Subscriber ID #:			
Group #:			
Patient ID(if different):			

BENEFIT ASSIGNMENT AND RELEASE OF INFORMATION

I, the undersigned, for myself or a minor child or another person for whole I have authority to sign, certify that the insurance information listed above is correct and that all insurance benefits for services rendered are directly assigned to Abbeville Surgical. I understand that I am financially responsible for all charges regardless of benefits. I hereby authorize the release of information necessary to secure payment of benefits. I hereby authorize the release of information necessary to secure payment of benefits. I authorize the use of this signature on all insurance claim submissions. Should this account be turned over to a collection agency for collection, I understand and agree that I will be obligated to pay all collection costs, including, but not limited to, reasonable attorney fees.

SIGNATURE _____

DATE _____

Patient Name: _____ Chart #: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

	YES	NO		YES	NO
HEART:	Heart Attack _____	_____	KIDNEY:	Infection _____	_____
	High Blood Pressure _____	_____		Stones _____	_____
	Irregular Heart Beat _____	_____		Failure(Dialysis) _____	_____
	Chest Pain _____	_____		Blood in Urine _____	_____
	CHF _____	_____			
LUNGS:	Smoke _____	_____	VASCULAR:	Circulation in Legs _____	_____
	Cough _____	_____		Circulation in Arms _____	_____
	Short of Breath _____	_____		Stroke _____	_____
	Emphysema/Asthma _____	_____		Aneurysm _____	_____
	Cough up blood _____	_____		Varicose Veins _____	_____
	COPD _____	_____		Blood Clot _____	_____
BREAST:	Lump or Cyst _____	_____	NERVOUS:	Loss of Movement _____	_____
	Pain _____	_____		Numbness Arm/Leg/Face _____	_____
	Discharge _____	_____		Speech _____	_____
	Change in Appearance _____	_____		Vision _____	_____
	Family History Change _____	_____		Dizziness _____	_____
ABDOMEN:			OTHER:	Syncope(black outs) _____	_____
				Diabetes _____	_____
				Arthritis _____	_____
				Thyroid _____	_____
				Emotional Disorder _____	_____
				Drink Alcohol _____	_____
				High Cholesterol _____	_____
				Rectal _____	_____
		Hemorrhoids _____	_____		
		Lesions _____	_____	_____	

INFECTIOUS DISEASE: (circle) Hepatitis AIDS/HIV Other(please explain)

PLEASE NOTIFY YOUR DOCTOR AND MEDICAL STAFF IF YOU ARE CURRENTLY TAKING BLOOD THINNERS SUCH AS COUMADIN, PLAVIX, OR ARE ON AN ASPIRIN REGIMIN**

MEDICATIONS (PLEASE LIST):

OPERATIONS:

ALLERGIES:

FAMILY HISTORY:

PHYSICIAN'S SIGNATURE

DATE