PERSONAL HISTORY: (PLEASE PRINT) DATE _____

NAME_____AGE _____

HOME ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE (___) _____ BUSINESS PHONE (___) _____

SOCIAL SECURITY #: _____ DRIVER'S LICENSE #: _____

DATE OF BIRTH _____/_____/_____ MALE / FEMALE_____

EMPLOYER_____OCCUPATION _____

BUSINESS ADDRESS_____

CITY_____STATE_____ZIP_____

E-MAIL ADDRESS_____ MARITAL STATUS_____

SPOUSE'S NAME_____ SPOUSE'S SOCIAL SECURITY #: _____

SPOUSE'S EMPLOYER_____ SPOUSE'S BUSINESS PHONE (___) _____

SPOUSE'S BUSINESS ADDRESS_____

CITY_____STATE_____ZIP_____

FAMILY PHYSICIAN: _____

PHYSICIAN'S ADDRESS_____

CITY_____STATE_____ZIP_____

REFERRED BY _____

NAME, ADDRESS & PHONE OF NEAREST RELATIVE (Other than spouse):

_____

_____

IN CASE OF EMERGENCY NOTIFY_____RELATIONSHIP_____

PHONE NUMBER (___) _____

I agree to pay for services rendered at time of service unless other arrangements have been made in advance. Office reserves the right to collect immediately on any past due amounts or assess a finance charge/interest to any outstanding balance.

X_____

Signature of Patient or Responsible Party Date

MEDICAL HISTORY

HISTORY OF PAST ILLNESS:

Have you had any of the following:

Measles……	No	Yes
Mumps…….	No	Yes
Chickenpox…….	No	Yes
Arthritis…….	No	Yes
Stomach/Intestinal…….	No	Yes
Liver Disease/Hepatitis…….	No	Yes
Kidney/Urinary Tract…….	No	Yes
Thyroid/Hormonal Disease…..	No	Yes
Venereal Disease……..	No	Yes
Congenital Abnormality……	No	Yes
Heart Disease……	No	Yes
High Blood Pressure…….	No	Yes
Rheumatic Fever……..	No	Yes
Diabetes…….	No	Yes
Asthma/Emphysema……	No	Yes
Bleeding tendency……	No	Yes
Blood Disorder……..	No	Yes
Anemia……	No	Yes
Herpes……	No	Yes
HIV+……	No	Yes
Pneumonia……	No	Yes
Tuberculosis……..	No	Yes
Poor Hearing…….	No	Yes
Keloid…….	No	Yes
Facial Paralysis…….	No	Yes
Breast Masses, Cysts……..	No	Yes
Tumors……	No	Yes
Cancer……	No	Yes

List Diseases known to be present in family members Relationship

Cancer _____

Tuberculosis _____

Diabetes _____

Heart Trouble _____

High Blood Pressure _____

Stroke/Epilepsy/Black outs _____

Convulsions _____

Suicide _____

Insanity _____

Bleeding Tendency _____

Gout _____

Arthritis _____

AIDS _____

List all Medications, nose drops, hormones, vitamins, etc. you are currently taking, including Aspirin.

_____

_____

_____

_____

List all allergies you have to Medications, Tape, Food, Pollens, etc.

_____

_____

_____

If you answered "yes" to any of the above, please indicate any information that may be helpful.

_____

Have you ever had any blood transfusions? If so, when? _____

List all surgeries you have had, please include dates. _____

_____

_____

Have you ever been hospitalized or been under medical care for a prolonged period of time, if so, when?

_____

Have you ever taken Anticoagulants (blood thinners)? _____

Have you ever taken Cortisone? _____

DO YOU SMOKE? _____ HOW MUCH? _____ DO YOU DRINK COFFEE OR TEA? _____
DO YOU DRINK ALCOHOL? _____ HOW MUCH? _____
DO YOU USE DRUGS? _____ MARIJUANA? _____ COCAINE? _____

INJURIES: (Please list dates)
Have you had any broken bones? _____
Have you had any head concussions or injuries? _____
Have you ever been knocked unconscious? _____

MEDICAL HISTORY: (CONT.)

What is your current weight? _____ height? _____

Are you pregnant? _____

SYSTEMIC REVIEW:
Do you have any of the following?

GENERAL:		
Recent weight change ……..	No	Yes
Good health most of you life…….	No	Yes
SKIN:		
Skin Disease…….	No	Yes
Jaundice…….	No	Yes
Hives, eczema or rash……	No	Yes
Frequent infection or boils……..	No	Yes
Abnormal pigmentation……	No	Yes
Other skin disease/injury……	No	Yes
HEAD/ EYES:		
Eye disease or injury……	No	Yes
Do you wear glasses…….	No	Yes
Do you wear contact lenses…….	No	Yes
Double vision……	No	Yes
Headaches……	No	Yes
Glaucoma……...	No	Yes
Other eye disease/ injury……	No	Yes

NOSE/ EARS:		
Sneezing/ runny nose……..	No	Yes
Nosebleeds…….	No	Yes
Chronic sinus trouble……	No	Yes
Ear disease……	No	Yes
Impaired hearing…….	No	Yes
Dizziness……..	No	Yes
Episodes of unconsciousness……...	No	Yes
Other nasal/ sinus disease/ injury……	No	Yes
NECK:		
Stiffness…….	No	Yes
Thyroid trouble…….	No	Yes
Enlarged glands…….	No	Yes
Other related disease……..	No	Yes
RESPIRATORY:		
URI (cold) now……...	No	Yes
Spitting up blood……	No	Yes
Chronic cough……	No	Yes

If any of the above answers are “yes”, please indicate the name of the disease, date diagnosed and treatment:
_____
_____
_____

Patient Signature: _____ Date: _____

INSURANCE INFORMATION:

INSURANCE CO: _____

ADDRESS: _____

SUBSCRIBER: _____ EMPLOYER: _____

GROUP NUMBER: _____ CERTIFICATE OR ID#: _____

SECONDARY INSURANCE CO.:

INSURANCE CO: _____

ADDRESS: _____

SUBSCRIBER: _____ EMPLOYER: _____

GROUP NUMBER: _____ CERTIFICATE OR ID#: _____

AUTHORIZATIONS:

PHOTOGRAPHIC CONSENT:

I hereby consent to be photographed for medical and/or scientific purposes. I understand that I may be photographed before, during, and/or after surgery and that this is an important part of my permanent record.

DATE____/____/____

SIGNED: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize my insurance benefits payable directly to William J. Binder, M.D., and I am financially responsible for all non-covered services. I authorize William J. Binder, M.D. to release to the insurance company any information required to process this claim.

DATE___/___/___

SIGNED: _____

AUTHORIZATION TO PAY BENEFITS TO SURGICAL FACILITY:

I hereby authorize my insurance benefits payable directly to Spalding Outpatient Surgery Center, LLC., and I am financially responsible for all non-covered services. I authorize Spalding Outpatient Surgery Center, LLC., to release to the insurance company any information to process this claim.

DATE___/___/___

SIGNED: _____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize above named physician to release any information acquired in the course of my examination or treatment.

DATE___/___/___

SIGNED: _____

EXPLANATION OF FINANCIAL ARRANGEMENTS:
PLEASE READ CAREFULLY

All surgical fees are payable in full two weeks in advance of your surgical date. A surgical deposit of **$500.00** is required on the day surgery is scheduled. Surgery **MUST** be cancelled 2 weeks **PRIOR** to your scheduled surgery date in order for your $500.00 deposit to be returned. Any surgery cancelled non-related to a medical issue **AFTER 2 weeks of your surgery date**, the **ENTIRE** surgical fee and deposit is **NON REFUNDABLE**.

All surgical cases billed to insurance will be subject to a 6.5% processing fee. Any monies received from your insurance carrier will have 6.5% deducted prior to any reimbursements made directly to you, if applicable. If courtesy billing is being done on your behalf, the 6.5% processing fee will also apply.

If, for any reason, you may require a secondary procedure, there will be operating room and anesthesia fees. In certain situations, your insurance may be billed.

In some surgical cases, a tissue specimen will be sent to a pathology lab. Federal law requires any tissue specimen with potential pathology be sent for evaluation. In addition, all insurance companies require a tissue specimen evaluation for proof of the procedure. If your surgery requires pathology, you will be responsible for the charges and billed directly from the laboratory.

Your surgical fee may be deducted on your income tax return under certain circumstances, but you should consult your accountant.

The initial consultation fee of **$150.00** is due and payable at the time of service. The consultation fee is non-refundable, regardless if you choose to undergo surgery or not.

If you have any questions regarding any of the above, please address them **prior** to seeing the doctor. Thank you in advance for your cooperation.

X_____ _____
Patient Signature **Date**

**If you are interested in receiving notifications and promotional emails from this office, please clearly print your email address below :

_____