

Christiana Institute of Advanced Surgery, P. A.
Office Registration Form

Name: _____ Birth Date: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Ph#: _____ Work Ph#: _____ Cell Ph#: _____
E-Mail Address: _____ Sex: Male _____ Female: _____
Soc. Sec. #: _____ Marital Status: _____ (S-Single, M-Married, D-Divorced, W-Widowed)
Race: __ American Indian __ Asian __ Native Hawaiian __ Black or African American __ White __ Hispanic __ Other Race
Ethnicity: __ Hispanic __ Non-Hispanic

Participating Pharmacy: _____ Phone #: _____

Primary Care Physician: _____ Phone#: _____
Referring Physician: _____ Phone#: _____
Employer Name: _____ Phone#: _____
Employer Address: _____
Occupation: _____ F/T or P/T _____

Emergency Contact: _____ Relation: _____
Address: _____ Phone#: _____

Primary Insurance: _____ Policy ID #: _____
Policy Holder's Name: _____ Soc. Sec. #: _____ Birth Date: _____

Secondary Insurance: _____ Policy ID #: _____
Policy Holder's Name: _____ Soc. Sec. #: _____ Birth Date: _____

1. I agree to bring my insurance card and co-pay (if applicable) to **every** appointment. I am aware that if I do not, my appointment may need to be cancelled and rescheduled.

Signature: _____

2. We may need to contact you with test results or other information. **What is the best way to contact you?**

Phone: _____ **Email:** _____ **Text:** _____

Please check one option:

_____ It will be **OK** for us to leave test results or messages on an answering machine, voice mail or with a family member. Please sign to show that you give us permission to leave messages.

Signature: _____

_____ We may **NOT** leave messages on answering machines or with a family member. If we can not reach you directly in a reasonable amount of time, I understand that letter will be sent to my address.

Signature: _____

I request that payment of authorized benefits Medicare, Medicaid, and/or any Insurance carrier listed, be made to me or on my behalf to the provider listed on this form, for any services furnished to me by my physician. I understand and agree that I will be responsible for any charges, i.e. co-payments, deductibles, or non-covered services not paid for by my insurance carrier. I authorize any holder of medical information about me to release it to the Division of Family Services, the Health Care Financing Administration, listed insurer(s), and/or agents of these companies, and/or the listed responsible person(s), any information needed to determine these benefits or the benefits for other related services rendered.

Signature: _____

CHRISTIANA INSTITUTE OF ADVANCED SURGERY

PATIENT HEALTH HISTORY

Name: _____ Today's date: _____

Social Security Number: _____ DOB: _____ Age: _____

Reason for visit: _____ Referred by: _____

List all medications (use back if you need extra space)

Drug: _____ Dose: _____ how often: _____
Drug: _____ Dose: _____ how often: _____
Drug: _____ Dose: _____ how often: _____
Drug: _____ Dose: _____ how often: _____

Do you take aspirin routinely? _____ Yes _____ No how often: _____

Do you have allergies to medications? 1. _____ 2. _____ 3. _____

Do you have allergies to latex? _____ Yes _____ No

Please check if you have had any of the following surgeries:

_____ Appendectomy _____ Gallbladder removed _____ Hernia repair
_____ Heart surgery _____ Hysterectomy _____ Colon surgery
_____ Breast surgery _____ Kidney transplant
_____ Others (Please list) _____

Please check if you have had any of the following medical problems:

_____ Mitral valve prolapse _____ Cancer _____ Emphysema
_____ Abnormal EKG _____ High blood pressure _____ Arthritis
_____ Angina _____ Heart attack _____ Lung disease
_____ Diabetes _____ Heart failure _____ Liver disease
_____ Bleeding problems _____ HIV _____ Kidney disease
_____ Others (please list) _____

If you are dialysis patient, what days are you dialyzed? _____

Dialysis unit? _____

List any problems with anesthesia in the past: _____

Last chest x-ray: _____ Last EKG: _____

Where did you have them done? _____

Do you smoke? _____ Packs per day? _____ Drink alcohol? _____ How often? _____

Any family history of: _____ Cancer _____ Diabetes _____ High blood pressure
_____ Stroke _____ Heart attack _____ Bleeding disorder

Date of last menstrual period: _____

Patient signature: _____ Date: _____

The above is true to the best of my belief.



DATE: _____

NAME: _____

RE: DISABILITY FORM / FMLA REQUEST

Dear Patient:

If you require disability forms to be completed prior to your scheduled surgery, our office needs a signed release and processing fee of \$20.00. A minimum of **Seven to Ten** business days are required for completion. There is no charge to complete an FMLA form.

Thank you in advance for following these simple directions it will enable our office to process your request more efficiently. Completed forms may be picked up or faxed. If you have any questions please call our office (302) 892-9900.

Sincerely,

Michael Clancy

Michael Clancy
Practice Administrator

SIGNATURE

DATE



PLEASE READ

THANK YOU for choosing CHRIAS to perform your surgery. We are pleased to work with you and value your individuality and time. We ask that you are mindful of other patient's and the surgeon's time as well by following a simple procedure when canceling office visits, procedures and surgery:

		<i>CHARGE FOR NO CALL, NO SHOW</i>
<u>CONSULTATION VISIT</u>	48 HRS NOTICE	\$100.00
<u>EGD PROCEDURE</u>	1 WEEK NOTICE	\$100.00
<u>GASTRIC/LAPBAND SURGERY</u>	1 MONTH NOTICE	\$100.00

Your cooperation in this matter is greatly appreciated by the CHRIAS staff and the patients of our Practice who wait patiently for appointments.

Patient signature

Date