BIRMINGHAM HAND & PLASTIC SURGERY

PATIENT INFORMATION QUESTIONNAIRE

Please complete this form in black ink

Patient Full Name: _____Date of Birth: _____

Social Security# _____ Age: _____ Marital Status: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone# (_____) _____ Cell/Mobile # (_____) _____

E-Mail Address: _____

Employer's Name:_____ Position Held: _____

In Case of Emergency Notify:

Name: _____ Relationship: _____

Home Phone# (_____) _____ Cell# (_____) _____ Other# (_____) _____

INSURANCE INFORMATION: (Please provide insurance cards)

Primary Insurance Name: _____

Secondary Insurance Name: _____

Birmingham Hand & Plastic Surgery will only file/bill two (2) insurances and does not bill 3rd parties.

Is this visit related to:

Job Injury: ☐ Auto Accident: ☐ Other injury/Accident: ☐ Date of Injury: _____

Primary Care Doctor/Family Physician: _____Phone # (_____) _____

I was referred by: _____ Phone # (_____) _____

Reason for office consult/visit:_____

PATIENT NAME:_____ **DATE:** _____

Surgical History: Please list ALL surgeries and the approximate date of the surgery.

PROCEDURE	DATE	PROCEDURE	DATE

Anesthesia: Have you ever had problems with: ☐ Local Anesthesia ☐ IV Sedation ☐ General Anesthesia

Medications: Please list ALL medications taken on a regular basis (include Aspirin, Birth Control, Coumadin, Herbal Meds., etc.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Allergies: Are you allergic to any drugs, anesthetic agents or other materials? (e.g., tape, iodine, food) ☐ No ☐ Yes
If YES, please note: _____
_____

Personal History: Height: _____ Current Weight: _____

Are you right or left handed?	☐ Right	☐ Left	
Do you have sleep apnea?	☐ No	☐ Yes	
Do you use C-Pap Machine?	☐ No	☐ Yes	
Are you disabled?	☐ No	☐ Yes	If yes, why: _____
Do you smoke?	☐ No	☐ Yes	If yes, how much? _____ Quit date: _____
Do you vape?	☐ No	☐ Yes	If yes, how much? _____ Quit date: _____
Do you drink alcoholic beverages on a regular basis?	☐ No	☐ Yes ☐ Socially	If yes, how much/week: _____

Family History: Please answer ALL

	YES	NO	RELATIONSHIP		YES	NO	RELATIONSHIP
Diabetes	____	____	_____	Breast Cancer	____	____	_____
Hypertension	____	____	_____	Other Cancer	____	____	_____
Heart Disease	____	____	_____	Stroke	____	____	_____
Melanoma	____	____	_____	Bleeding problem	____	____	_____
Skin Cancer	____	____	_____	Other	____	____	_____

MEDICAL & SURGICAL HISTORY

PATIENT NAME: _____ DATE: _____

CHECK ALL THAT APPLY → → CHECK NONE, IF NONE APPLY → → *Thank you!*

GENERAL & HORMONAL
- ☐ Eating Disorder
- ☐ Thyroid Disease
- ☐ Chronic Fatigue Syndrome
- ☐ Chronic Disease
- ☐ Cancer TYPE_____
- ☐ Non-insulin Dependent Diabetes
- ☐ Insulin Dependent Diabetes
- ☐ OTHER: _____
- ☐ **NONE**

INTEGUMENT (SKIN)
- ☐ Skin Cancer ☐ Melanoma
- ☐ Dysplastic Nevi ☐ Acné
- ☐ Rosácea ☐ Eczema
- ☐ Psoriasis
- ☐ OTHER: _____
- ☐ **NONE**

BREAST – Right / Left / Bilateral
- ☐ Biopsy R L B
- ☐ Cyst Drained R L B
- ☐ Lumpectomy R L B
- ☐ Mastectomy R L B
- ☐ Reconstruction R L B
- ☐ Implant(s) R L B
- ☐ OTHER: _____
- ☐ **NONE**

HEAD & NECK
- ☐ Trauma ☐ Neurosurgery
- ☐ Facial Surgery
- ☐ Brain Shunt
- ☐ Thyroid Surgery
- ☐ Cervical Disc Surgery
- ☐ Arthritis in Neck
- ☐ Lymph Node Removed
- ☐ Cervical Disc Disease
- ☐ Carotid Artery Surgery
- ☐ Thyroid Surgery
- ☐ OTHER: _____
- ☐ **NONE**

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Pins and/or screws for fracture
- ☐ Knee &/or ☐ Hip Replacement
- ☐ Back Surgery
- ☐ OTHER: _____
- ☐ **NONE**

EYES / EARS / NOSE
- ☐ Glaucoma
- ☐ Cataract Surgery
- ☐ Eye Muscle Surgery
- ☐ Eyelid Surgery
- ☐ Hearing Aid
- ☐ Cochlear Surgery
- ☐ Skin Cancer Surgery
- ☐ Ears "pinned back
- ☐ Sinus Surgery
- ☐ Nasal Surgery/Broken Nose
- ☐ Septal Surgery ☐ Rhinoplasty
- ☐ OTHER: _____
- ☐ **NONE**

CARDIOVASCULAR & RESPIRATORY
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Pacemaker
- ☐ Chest Pain
- ☐ Heart Rhythm Abnormality
- ☐ Heart By-pass Surgery
- ☐ Heart Valve Surgery
- ☐ Mitral Valve Prolapsed
- ☐ Implanted Defibrillator
- ☐ Aneurysm Repair
- ☐ OTHER: _____
- ☐ **NONE**

GASTROINTESTINAL
- ☐ Gastric By-pass Surgery
- ☐ Hernia Repair
- ☐ Gallbladder Surgery
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Colon Cancer
- ☐ OTHER: _____
- ☐ **NONE**

GENITOURINARY - WOMEN
- ☐ Hysterectomy
- ☐ Endometriosis
- ☐ Ovarian Cysts
- ☐ Abnormal PAP
- ☐ Childbirth # _____
- ☐ C-Section # _____
- ☐ OTHER: _____
- ☐ **NONE**

GENITOURINARY - MEN
- ☐ Testicular Surgery
- ☐ Penile Prosthesis
- ☐ OTHER: _____
- ☐ **NONE**

GENITOURINARY – ALL
- ☐ Biopsy: _____
- ☐ Lesion Removed ☐ Hernia Repaired ☐ Kidney Stones
- ☐ Kidney Transplant
- ☐ Kidney Disease
- ☐ OTHER: _____
- ☐ **NONE**

NERVE/NEUROLOGIC & PSYCHIATRIC
- ☐ Neuropathy ☐ Shingles
- ☐ Seizure Disorder
- ☐ Stroke ☐ Migraines
- ☐ Headaches
- ☐ Carpal Tunnel Syndrome
- ☐ Depression
- ☐ Drug Dependency
- ☐ Alcoholism
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Anxiety Disorder
- ☐ ADHD/ADD
- ☐ OTHER: _____
- ☐ **NONE**

BLOOD DISEASE & IMMUNE SYSTEM
- ☐ Anemia ☐ Leukemia
- ☐ Sickle Cell Syndrome
- ☐ Fibromyalgia
- ☐ High Platelet Count
- ☐ Low Platelet Count
- ☐ Rheumatoid Arthritis
- ☐ Scleroderma ☐ Lupus
- ☐ Organ Transplant
- ☐ Lymphoma
- ☐ Hodgkin's disease
- ☐ HIV/AIDS
- ☐ OTHER: _____
- ☐ **NONE**

Patient Signature: _____ Date: _____

REVIEW of SYSTEMS

CHECK ALL THAT APPLY → → CHECK NONE, IF NONE APPLY → → SIGN & DATE at the bottom. *Thank you!*

GENERAL/CONSTITUTIONAL
☐ Fever ☐ Fatigue or Malaise
☐ Flu-like Symptoms
☐ Unexplained Weight - / +
☐ OTHER: _____ ☐ **NONE**

HEAD/SKULL
☐ Lumps ☐ Irregularities
☐ Pain ☐ Lesions
☐ Congenital / Surgical Defects
☐ OTHER: _____ ☐ **NONE**

EYES
☐ Blurred/Double Vision
☐ Loss of Vision
☐ Difficulty Seeing at Night
☐ Irritated, Itchy, Watery
☐ Eye Pain ☐ Discharge
☐ OTHER: _____ ☐ **NONE**

EARS
☐ Pain/Earache ☐ Drainage
☐ Difficulty Hearing ☐ Dizziness
☐ Ringing in the Ears
☐ OTHER: _____ ☐ **NONE**

NOSE
☐ Pain ☐ Irritation ☐ Drainage
☐ Discharge ☐ Loud Snoring
☐ Problems Breathing
☐ OTHER: _____ ☐ **NONE**

THROAT
☐ Pain ☐ Sore ☐ Hoarseness
☐ Irritation / Redness
☐ Trouble Swallowing / Speaking
☐ OTHER: _____ ☐ **NONE**

NECK
☐ Pain or Stiffness ☐ Growths
☐ Lumps/ Bumps ☐ Lymph Nodes
☐ OTHER: _____ ☐ **NONE**

RESPIRATORY
☐ Cough ☐ Short of Breath
☐ Sputum Production
☐ Cough Blood ☐ Wheezing
☐ Pain w/ Deep Breath
☐ Stop Breathing when Sleeping
☐ OTHER: _____ ☐ **NONE**

PSYCHIATRIC
☐ Frequently Depressed
☐ Constant Anxiety ☐ Paranoia
☐ Memory Loss ☐ Suicidal Thoughts ☐ Hallucinations
☐ OTHER: _____ ☐ **NONE**

MUSCULOSKELETAL
☐ Joint Pain, Swelling
☐ Muscle Pain, Stiffness
☐ Upper Back Pain ☐ Lower Back Pain ☐ Shoulder Pain
☐ OTHER: _____ ☐ **NONE**

GASTROINTESTINAL
☐ Nausea/Vomiting ☐ Chronic Diarrhea ☐ Chronic Constipation
☐ Change in Bowel Habit
☐ Abdominal Pain ☐ Frequent Dark Black Stools ☐ Blood in Stools
☐ Jaundice (yellow skin)
☐ Pain/Discomfort after Eating
☐ OTHER: _____ ☐ **NONE**

GENITOURINARY-WOMEN
☐ Vaginal Irritation/Discharge
☐ Menstrual Irregularities
☐ OTHER: _____ ☐ **NONE**

GENITOURINARY – ALL
☐ Pain/Discharge w/ Urination
☐ Frequent/Urgent Urination
☐ Recent Change in Urinary Habits
☐ Rashes, Sores, Growths
☐ OTHER: _____ ☐ **NONE**

NEUROLOGIC
☐ Seizures ☐ Tremors
☐ Weakness ☐ Numbness
☐ Tingling ☐ Poor Balance
☐ Difficulty Walking ☐ Dizziness
☐ Temp Paralysis ☐ Inability to talk
☐ OTHER: _____ ☐ **NONE**

PROVIDER INITIALS _____

DATE _____

CARDIOVASCULAR
☐ Chest Pain ☐ Palpitations / Skipped Beats ☐ Fainting Spells
☐ Leg Swelling ☐ Shortness of Breath on Exertion ☐ Shortness of Breath if Sleeps Flat
☐ OTHER: _____ ☐ **NONE**

INTEGUMENTARY (SKIN)
☐ Painful Are ☐ Rash, Itching, Dryness ☐ Unusual Lesions/Crusted Areas ☐ Wounds/Lumps/Bumps
☐ Acne ☐ Redness ☐ Drainage
☐ OTHER: _____ ☐ **NONE**

ENDOCRINE (HORMONAL)
☐ Increased Hunger ☐ Increased Thirst ☐ Frequent Urination
☐ Heat or Cold Intolerance
☐ Excessive Sleepiness after Meals
☐ Tingling and/or Numbness in Fingers and/or Toes
☐ OTHER: _____ ☐ **NONE**

BREAST
☐ Lumps, Bumps, Dimpling
☐ Drainage/ Discharge ☐ Pain
☐ Change in Size ☐ Shoulder Grooving ☐ Stretch Marks
☐ OTHER: _____ ☐ **NONE**

HEMATOLOGIC
☐ Abnormal or Prolonged Bleeding
☐ Bruising ☐ Fatigue ☐ Pallor
☐ OTHER: _____ ☐ **NONE**

ALLERGIES
☐ Frequent Sneezing ☐ Itchy / Watery
☐ Runny Nose ☐ Hay Fever / Hives
☐ OTHER: _____ ☐ **NONE**

IMMUNOLOGIC
☐ Exposure to HIV/AIDS ☐ Exposure to Hepatitis
☐ Frequent or Persistent Infections
☐ Slow to Heal
☐ Enlarged Lymph Nodes or Glands in Axillary area, Groin, or Neck
☐ OTHER: _____ ☐ **NONE**

Patient Signature _____ Date _____

BIRMINGHAM HAND & PLASTIC SURGERY

Consent for Purposes of Treatment, Payment and Healthcare Operations

- I authorize/consent this office to release my medical information to authorized persons such as doctors, insurance companies, or attorneys as the case may be.
- I authorize/consent Birmingham Hand & Plastic Surgery and staff to conduct any diagnostic examinations, tests and procedures and to provide medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my physician to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and benefits associated with such options.
- I authorize/consent to be photographed provided my identity is not revealed in the photo or text and the photos are to be used for medical purposes only.
- I understand that in giving my general consent for treatment I still retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my treating physician. I also understand that the practice of medicine is not an exact science and that no guarantees or warranties have been made to me as to the results of my evaluation and/or treatment.

I consent to the use or disclosure of my protected health information by Birmingham Hand & Plastic Surgery for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Birmingham Hand & Plastic Surgery. This protected health information may be used or disclosed to the Medical Association of the State of Alabama's Third Party Task Force to advocate on behalf of Birmingham Hand & Plastic Surgery and myself in the resolution of payment/reimbursement issue with _____ and/or its affiliated entities.
Insurance Carrier Name

I understand that:

- This office files my insurance as a courtesy, but I am held financially responsible for any charges I incur or that are not covered by my insurance company.
- I have the right to review and obtain a copy of the Office Billing Policy and Notice of Privacy Practice.
- Account balance must be paid in full within 60 days after the mailing of the first bill. The unpaid account will be forward to a Collection Agency, and I will be responsible for payment of a collection fee equal to 20% of the outstanding balance, in addition to the unpaid account balance. Should it be necessary, Attorney's Fees and/or Court costs will be added to the unpaid balance and collection fees. I hereby waive all rights of exemption under the U.S. and Alabama Constitutions and the laws of the State of Alabama.
- It may become necessary to release my protected health information to credit card entities and banks, when requested, to facilitate your payment.
- Services rendered and paid with a credit card are not eligible for payment challenges after services are provided. I am irrevocably consenting to allow Birmingham Hand & Plastic Surgery to use and disclose my protected health information to any Credit Card Entity or bank when they request such information to process an account and assist with payment. I will not challenge such credit or debit card payments once the services are provided.

I authorize/Consent:

- The direct payment to Paul F. Sauer, M.D. d/b/a Birmingham Hand & Plastic Surgery from the insurance company/carrier on record.
- To be contacted by email, text and/or telephone at any phone number including wireless phone numbers. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device in order to service my account or to collect money I may owe to Birmingham Hand & Plastic Surgery.

_____ _____
Patient's Signature **Date**

MEDICARE PART B EXTENDED PATIENT SIGNATURE AUTHORIZATION

Statement for payment of Medicare and MediGap benefits

I requested that payment of authorized MEDICARE and MEDIGAP benefits be made on my behalf to Paul F. Sauer, M.D. d/b/a Birmingham Hand & Plastic Surgery for any services or items rendered to me by the physician or supplier.
I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

_____ _____
Signature of Medicare Beneficiary or person signing for Beneficiary Date

_____ _____
Address of Person Signing for Beneficiary (Street, City, State, Zip) Relationship to Beneficiary