Surgery Consultants Of Oxford

2169 S Lamar Ave
Oxford, MS 38655-5223
(662) 234-1530

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)	ETHNICITY

CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP	HOME PHONE	RACE

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN	CONTACT NAME	CONTACT HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)
CITY, STATE ZIP	CITY, STATE ZIP
HOME PHONE	HOME PHONE
RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT $	
CITY, STATE ZIP	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#
ADDRESS OF INSURANCE COMPANY			COPAY AMT $
CITY, STATE ZIP			DEDUCTIBLE $
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SIGNATURE OF PATIENT/GUARDIAN

DATE

SURGERY CONSULTANTS OF OXFORD

PERSONAL MEDICAL INFORMATION SHEET

Name: _____ Date: _____

ALLERGIES: _____

_____

Latex allergy? Yes or No Iodine allergy? Yes or No

Past Medical History:

_____ Arthritis _____ Diabetes (Non-Insulin) _____ High Cholesterol _____ Stroke

_____ Asthma _____ Emphysema _____ Hist. of Blood Clot _____ Tuberculosis

_____ CHF (Cong heart failure) _____ Heart Attack _____ Pneumonia Other: _____

_____ Diabetes (Insulin) _____ High Blood Pressure _____ Stomach Ulcers _____

Cancer: Specify: _____

Past Surgical History:

_____ Tonsillectomy _____ EGD _____ Back/ Disc Surgery _____ C-Section

_____ Thyroid/ Parathyroid _____ Recent Heart Stents _____ Colonoscopy _____ Hemorrhoidectomy

_____ Breast Surgery (Specify) _____ Hernia (Specify) _____ Tubal Ligation _____ Gallbladder

_____ CABG _____ Appendix _____ Hysterectomy (Partial, Complete)

Others: _____

_____

Medications: Must include name, strength, frequency (may use back)

Drug/ Med	Strength	Route/ Frequency	Prescriber

Do you smoke? Yes or No How much: _____

Do you drink alcohol? Yes or No How much: _____

Occupation: _____

Family Medical History: (Diabetes, Hypertension, Cancer (Specify), etc.)

Mom: _____ Dad: _____

Brothers or Sisters: _____

ACCEPTANCE OF DISCLOSURE STATEMENT:

I have received a copy of the Notice of Privacy Practices for Protected Health Informatio and have had an opportunity to ask questions concerning that Notice given to me by Surger Consultants of Oxford.

RELEASE OF PRESCRIPTION HISTORY:

I authorize the staff of Surgery Consultants of Oxford to obtain my prescription history to help provide an accurate list of my medications.

CURRENT PHARMACY:

Name: _____ City/Location: _____

Phone: _____ Fax: _____

MEDICAL WAIVER:

This is to authorize my physician, to speak with _____, who is my
(Name of contact person)
_____ , and discuss with them the medical treatment I have been receiving from my physician and his clinic and any other
(Relationship)
matters related to that medical treatment.

In addition, the doctor, nurse, or office staff may need to leave a message on your answering machine when trying to contact you or your contact person listed above. Do you approve _____ , or disapprove _____ ? (Please mark with and X for your answer)

This authorization shall remain in effect until such times as it is withdrawn by me, in writing, regardless of the date signed.

CONTACT PHONE NUMBERS:

Home: _____ Cell: _____

Other: _____

_____
Patient's Signature

_____
Witness

_____
Date