CUMBERLAND SURGICAL ASSOCIATES, PLC

RICHARD TERRY, M.D. SUSAN BRILEY, M.D. MARIA FREXES, M.D. WILLIAM HARB, M.D.

Patient Name: _____ DOB: _____
(Last) (First) (Middle)

Social Security Number: _____ - _____ - _____ Marital Status: S ____ M____ D ____W ___ Sex: M_____ F_____

Physical Street Address: _____

Mailing Address: _____

City: _____ State _____ Zip Code: _____

Home phone: (_____) _____ Work phone: (_____) _____ Cell # (_____)_____

Emergency Contact Name: _____Emergency Contact Phone: (_____) _____

Responsible Party Name: _____ _____
(Last) (First) (Middle) Relationship to Patient

Social Security Number: _____ - _____ - _____ Hone Phone (_____)_____Cell # (_____)_____

Responsible Party Address: _____

City: _____ State _____ Zip Code: _____

Employer's Name: _____ Work Phone: (_____) _____

INSURANCE INFORMATION *Please provide Insurance Card and Photo ID to Receptionist (Necessary forms will be completed to help expedite claims. However, the patient or responsible party is responsible for all fees, regardless of insurance coverage.

Primary Insurance Company's Name: _____

Insurance Address: _____

City: _____ State _____ Zip Code: _____

Name of Policy Holder: _____Date of Birth: _____

Insurance ID Number: _____ Group Number: _____

Secondary Insurance Company's Name: _____

Insurance Address: _____

City: _____ State _____ Zip Code: _____

Name of Policy Holder: _____Date of Birth: _____

Insurance ID Number: _____ Group Number: _____

I hereby authorize my insurance benefits to be paid directly to Drs. Terry, Briley, Frexes or Harb for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits. My signature below also serves as an authorization for copies of any and all medical records concerning my medical condition to be sent to Dr. Richard Terry, Dr. Susan Briley, Dr. Maria Frexes or Dr. William Harb.

Signature of Responsible Party: _____Date: _____

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NAME: _____ **DATE:** _____ **AGE:** _____

Referring Phys: _____ Primary Care Physician: _____

What is your reason for today's visit? _____

1. When did this problem start? _____
2. Where is this problem located? _____
3. What makes this problem worse? _____
4. Is there any other symptom associated with this problem? Yes ___ No _____

Describe _____

Previous Surgery (of any kind) _____

_____

_____

Previous Hospitalizations: _____

Radiation Treatment: _____

Medical Conditions: Heart Disease [ ] Diabetes [ ] Stroke [ ] Cancer [ ] type _____

Hepatitis [ ] Asthma [ ] Other [ ] High Blood Pressure [ ] HIV [ ]

Medicines and Dose (including aspirin/laxatives) _____

_____

_____

Allergies (please describe reaction) _____

FAMILY HISTORY: (Please check if you have a father, mother, sister, or brother with):

Colon-Rectal Cancer [ ] Breast Cancer [ ] Heart Disease [ ] Diabetes [ ]

Ovarian/Uterine Cancer [ ] Ulcerative Colitis [ ] Crohn's Disease [ ] Stroke [ ]

Bleeding Problems [ ] Other [ ] _____

SOCIAL HISTORY

Occupation _____

Tobacco Yes____ No____ Alcohol Yes____ No_____

_____ _____

Patient Signature Physician Signature

NAME: _____

MENSTRUAL HISTORY:

Pregnancies _____ Deliveries _____

Last Period _____ Last PAP smear _____ Results _____

Last Mammogram _____ Results _____

Are you pregnant? Yes _____ No _____ Vaginal Bleeding _____

REVIEW OF SYSTEMS: Are you currently having any of the following?

1. GENERAL: Weight Loss ☐ Fever ☐ Chills ☐ Anemia ☐ Poor Appetite ☐
2. EENT: Loss of Vision ☐ Difficulty Swallowing ☐ Mouth Ulcers ☐
3. CARDIOVASCULAR: Chest Pain ☐ Ankle Swelling ☐ Shortness of Breath ☐
   Pain in Legs with Walking ☐ Shortness of Breath Lying Down ☐
4. RESPIRATORY: Cough ☐ Wheezing ☐ Coughing Blood ☐
5. GI: Abdominal Pain ☐ Diarrhea ☐ Constipation ☐ Vomiting ☐ Rectal Itching ☐
   Rectal Bleeding ☐ Rectal Pain ☐ Rectal Leakage ☐ Black Stools ☐ Jaundice ☐
   Last Colonoscopy _____ Results _____
6. URINARY: Blood in Urine ☐ Urine Leakage ☐ Painful Urination ☐
   Difficult Urination ☐ Night-time Urination ☐ Impotence ☐
7. MUSCLES: Arthritis ☐ Joint Pain ☐ Back Pain ☐ History Broken Bones ☐
8. BREAST/SKIN: Rashes ☐ Breast Pain ☐ Breast Lump ☐ Nipple Discharge ☐
9. NEURO/PSYCH: Fainting Spells ☐ Seizures ☐ Depression ☐ Headache ☐
   Confusion ☐ Numbness ☐ Muscle Weakness ☐
10. ENDOCRINE/LYMPHATIC: Palpitations ☐ Fatigue ☐
    Hair Loss ☐ Night Sweats ☐

Nurse _____ Physician _____
Signature Signature

Patient _____
Signature