

Goco Surgical Associates, PLLC

General & Laparoscopic Surgery

Lori Goco Kellam, M.D.

PATIENT REGISTRATION

Date _____

Social Security No. _____

Driver's License No. _____

And State _____

PERSONAL (PLEASE PRINT)

Last Name _____ First _____ Middle _____ Maiden _____

Mailing Address _____

Physical Address _____ Cell # _____

City _____ State _____ Zip _____ Home Phone _____

Date of Birth _____ Age _____ Sex Male Female Marital Status _____

Referred By _____ (If Doctor – Give Address) _____

Family Doctor _____ Phone _____

Address _____

EMPLOYMENT

Patient Employer _____ Occupation _____

Address of Employer _____

City _____ State _____ Zip _____ Employer Phone _____

SPOUSE OR NEAREST RELATIVE

Last Name _____ First & Middle _____ Relationship _____

Employer _____

Address of Employer _____

City _____ State _____ Zip _____ Employer # _____

Home # _____

INSURANCE (PLEASE PRESENT YOUR INSURANCE CARD(S) FOR COPYING

If your insurance card is in a name other than the patient's name, please provide the following information.

Name _____ Date of Birth _____

Social Security # _____

WE ARE HAPPY TO FILE YOUR INSURANCE CLAIMS FOR YOU.

HOWEVER, WE DO EXPECT ACCOUNTS PAID IN FULL WITHIN 90 DAYS FROM DATE OF SERVICES.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician of this surgical and/or medical benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services (unless otherwise stated).

SIGNED (Patient or Guardian)

DATE

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

SIGNED (Patient or Guardian)

DATE

PLEASE COMPLETE THE INFORMATION ON THE BACK OF THIS FORM.

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Patient Name _____

Current medical Complaint

Date of Onset of Problem _____ Related to Accident or Injury Yes No Date _____

Check or list any medical conditions you have or had previously:

- | | | |
|---|--|---|
| <input type="checkbox"/> Hypertension (High Blood Pressure) | <input type="checkbox"/> Pulmonary or Lung Disease | <input type="checkbox"/> Renal or Kidney Disease |
| <input type="checkbox"/> Heart Disease or Angina | <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Peptic Ulcer Disease / Hiatal Hernia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Cancer (Type _____) | <input type="checkbox"/> Psychiatric Illness |

Have you ever been tested POSITIVE for TB) Yes No IF YES, PLEASE EXPLAIN

Other _____

Family History of any of the above

Previous Surgery or Hospitalization (Date and Reason)

Do you use tobacco products? Yes No How many packs per day? _____
Do you drink alcoholic beverages? Yes No Regularly or Occasionally

List any medicines to which you have an Allergy and the Reaction

List your present medication and dosage

PLEASE GIVE US YOUR INSURANCE CARD(S) SO THAT WE CAN MAKE A COPY FOR OUR FILE.