NEW PATIENT INFORMATION

NAME_____________________________________ DATE OF BIRTH_______________________
ADDRESS____ CITY____________________________
STATE____________ ZIP CODE _____________ EMAIL___________________________________
HOME PHONE_____________________________ CELL PHONE___________________________

CIVIL STATUS: o MINOR o SINGLE o MARRIED o DIVORCED o WIDOWED

PARENT/GUARDIAN NAME____
SSN# _____________ RACE_______________ PRIMARY LANGUAGE ______________________
EMPLOYER___________________________________ WORK PHONE _______________________
ADDRESS____________________________________ CITY___________ STATE______________

RESPONSIBLE PARTY (IF UNDER 18)

NAME____
RELATIONSHIP TO PERSON__________________ BIRTHDATE___________ SSN_____________
ADDRESS_________________________ CITY______________ STATE________ ZIP CODE______
HOME PHONE_________________________________ CELLPHONE________________________

EMERGENCY CONTACT

NAME___________________________________ RELATIONSHIP___________________________
ADDRESS_________________________ CITY______________ STATE________ ZIP CODE______
HOME PHONE_____________________________ CELLPHONE_____________________________

NAME___________________________________ RELATIONSHIP___________________________
ADDRESS_________________________ CITY______________ STATE________ ZIP CODE______
HOME PHONE_____________________________ CELLPHONE_____________________________

SIGNATURE____ **DATE**________________________

BLASINGAME
SURGICALCARE

PATIENT HISTORY

First: ______________________ Last: ____________________ Hand Dominance: o Right o Left
Height: _______________ Weight: ____________ Primary Care Physician: _______________________
Who referred you to our clinic? ____
Do you see any other medical specialists (i.e. cardiologist, etc.)? If yes, please list__________________
____
Pharmacy name and address: ____

Current Medications/dosages taking: ____
____
____

Previous Surgeries/Dates: ____
____
____
Smoking History: Do you smoke? ___________ How many pack/day? ______________
If so how long have you smoked? ___________________________
Former smokers how long ago did you quit? _______________________________

Alcohol use: Nondrinker? ________________________
Less than 6 drinks/week? _________ 6 or more drinks a week? ______________
Type of Alcohol __________________________________

Personal Medical History: Have you ever had or do you now have: (check YES or NO)

	Yes	No		Yes	No
1. Shortness of Breath			22. Excessive Scarring/keloid		
3. Asthma			24. Vomiting Blood/Black Stools		
4. Chronic Bronchitis			25. Recent Gain or Loss in Weight		
5. Frequent Cold/Cough			26. Hemorrhoids		
6. Heart Disease			27. Hernia		
7. High or Low Blood Pressure			28. Kidney Trouble or Nephritis		
8. Heart Valve Probs/Murmurs			29. Painful or Bloody Urination		
9. Breast Problem/Disease			30. Low Back Trouble/Backache		
10. Back Pain			31. Varicose Veins		
11. Ankle Swelling			32. Blood Clots		
12. Easy Bruising			33. Radiation Therapy		
13. Excessive Bleeding			32. Blood Clots		
14. Anemia or Blood disease			34. Epilepsy or Seizures		
15. Thyroid disease			35. Emotional/Psychiatric Problems		
16. Rash			37. AIDS or HIV		
17. Diabetes			38. Facial Paralysis or Numbness		
18. Skin Cancer			39. Limited Activity		
19. Arthritis/Joint Problems			40. Anesthesia Problems		
20. Chronic Diarrhea/Bowel Trb.			41. Herpes or Fever Blisters		
21. Hepatitis/Jaundice/Liver Trb.			42. Eating Disorder		

GENERAL CONSENT AND DISCLOSURE

The information in this consent form is given so that you will be better informed about the health care services you will receive. After you are sure you understand the information which will be given about the services, and if you agree to receive the services, you must sign this form to indicate that you understand and consent to the services.

Dr. Jay Blasingame encourages individuals to seek a personal physician for periodic health examinations and for treatment of health problems. The clinic services are targeted primarily toward prevention of health problems among those who cannot access a physician. The clinic cannot assume the responsibility for payment of medical care received outside this clinic, i.e, surgical procedures.

DISCLAIMER ON SCREENING: Among its services, the clinic utilizes screening tests, which are a method of identifying individuals who are at risk for developing several common medical problems. In this way they can alert you to promptly seek medical evaluation and treatment from a private physician of your choosing. Screening tests perform valuable service in helping to find certain diseases early in their course. However, these screening tests do not cover all diseases and they may miss some cases of diseases they are intended to find. They are not diagnosed and they do not constitute a complete exam.

GENERAL CONSENT: I give permission to the clinic, its designated staff and other medical personnel providing services under its sponsorship to perform physical assessments or examinations, conduct laboratory or other tests, give injection, medications, other treatments, and render other health services to the patient identified on this form.

INFORMED CONSENT: In addition to the above general consent, I understand that special informed consent forms must be read and signed. This statement may inform the client that communicable disease information will be reported as is required by law, irrespective of client consent.

I certify that this form has been fully explained to me, that any blank lines have been filled and that any questions I have had about the services have been answered to my satisfaction.

Patient Name: ____________________________________ Date: _________________________

Signature: ____

Relationship: (if under 18): ____

I hereby grant permission to the authorities of Ochiltree Hospital District and the medical staff to perform such medical and or surgical procedures they may deem necessary, understanding the same and certifying that no guarantee or assurance has been made as to the results that may be obtained and to release such information contained in this report to the attending physician or company physician or insurance company as necessary for completion of hospital claims. I hereby authorize payment directly to Ochiltree Hospital District of any hospital insurance benefits otherwise payable to me. I understand I am financially responsible to the district of all charges, notwithstanding any benefits that might be payable by hospital insurance.

3020 Garrett Drive | Perryton, Texas 79070
P (806) 648-4288 F (806) 228-7771
ochiltreehospital.com/blasingame-surgical-care

PATIENT QUESTIONNAIRE

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

___

2. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

   Name__________________________________ Phone Number______________________
   Name__________________________________ Phone Number______________________

3. Please print the address of where you would like your billing statement and/or correspondence from our office to be sent if other than your home.

___

4. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number.

___

5. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine, voicemail? Or with anyone who answers your home phone?

   YES________ NO ________

Patient Name (Guardian if under 18): ____

Patient/ Guardian Signature___________________________________ DATE: ______________

GENERAL CONSENT/PROCEDURE CONSENT FORM

I, ___________________________________, on this date, _________________________,
Patient's full name *Date of Procedure*

Understand that I am having the following procedure: _______________________________
Name of procedure

For the following reason: ____.
Reason for procedure

I understand that there are risks with any medical procedure and these are as follows:

-
-
-

I, _______________________________ acknowledge these risks and authorize, Dr. Jay
Patient's full name
Blasingame, M.D. to perform this procedure.

____
Signature of Patient/Guardian of patient

____
Date signed

____
Person obtaining consent/witness

____
Date signed