To be filled out by all patients

Surgery Center of Zachary

Pre-Admission Information

(To be filled out with **each** visit)

What is the purpose of todays visit________________________________

Are you a diabetic? Yes / No If yes, did you check your blood sugar today? Yes / No
When was the last time you had anything to eat or drink?___________________________

(this includes gum, mints, tobacco products)

Who will be taking you home today? (please list name) ____________________ Phone number___________

Your pain level today in the area of your body we are working on.

(use 0-10 pain scale)________0= No pain 10= Worst imaginable pain

In order to protect your health information please provide the following:

* A follow up call will be placed to you on the next business day following your visit with us. Please provide us with a phone number we may call.______________Home/Cell/Work.

* May we leave a message at the above listed number? YES / NO

* May we speak with anyone who answers the phone? YES / NO

* May we inform other of your presence in our Center? YES / NO

* Do you have any health information that you would like to be kept confidential from any person or persons with you here today, If so, please specify those persons Zachary Surgical Center or your physician may **NOT** speak with

:______________________

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

Females only: Are you pregnant or is there any chance you may be pregnant? YES / NO

Date of last menstrual period___________________Have you had a hysterectomy or tubal ligation YES / NO

FOR RETURNING PATIENTS ONLY: ***Please take the time to complete so that we can update your medical history and medication sheet with any changes.***

*Has there been any change in you medical history since your last visit? (example: hospitalizations, new medications, new allergies, new diagnoses/ illness) Please explain_______________________________________

*Please add the following medication(s) to my medication and allergy sheet_______________________________

*Please remove the following medications from my medication and allergy sheet__________________________

Reviewed by:_______________________________(nursing staff)

Patient or Authorized Person Signature________________________________**Date**______________________

Relationship to patient if patient unable to sign________________________