Somerset Surgical Associates

Patient Information

Patient Name_____ Sex: M F Today's Date_____

Preferred Name_____ Preferred Pronoun ☐ He ☐ She ☐ Other_____

Marital Status_____ Name of Spouse (if applicable)_____

Social Security Number_____ Date of Birth_____ Age_____

Preferred Language: ☐ English ☐ Spanish ☐ Other Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Refuse to report

Race: ☐ White ☐ Black ☐ Hispanic ☐ Other ☐ Refuse to report

Street Address_____ City_____ State____ Zip_____

Home Phone #_____ Cell Phone #_____ Work #_____

Student ☐ Yes ☐ No School_____

Employer_____ Length of Employment_____

Email address _____
By providing your email, you will be invited to register in our patient portal.

Emergency Contact

Name/Relationship_____ Contact #_____

Referring Physician Information

Referring Physician_____

Phone #_____ Fax # _____

Street Address_____ City_____ State____ Zip_____

Primary Physician _____

Phone_____ Fax #_____

Street Address_____ City_____ State____ Zip_____

Pharmacy

Name of Pharmacy_____ City_____

Phone # _____ Fax # _____

Consent for R xHub Inquiry

I hereby provide my consent for Somerset Surgical Associates to obtain my Rx history using the Surescripts RxHub network. I understand this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefit Management (PBM) and retail pharmacies. I also understand that Surescripts RxHub follows strict security protocols to align with HIPAA requirements and respects patient privacy. All queries and responses are made automatically through secure system to system communications.

Your name:_____ Signature:_____ Date:_____

Somerset Surgical Associates

Name: _____

Reason for this visit: _____

Medication:

Please list all medications & dosage (including vitamins) you are currently taking:

Medical History: (check all that apply)

☐ asthma	☐ COPD	☐ diabetes	☐ tuberculosis
☐ heart attack	☐ heart disease	☐ heart murmur	☐ hypertension
☐ high cholesterol	☐ stroke	☐ GERD/gastritis	☐ peripheral vascular disease
☐ peptic ulcer	☐ thyroid disorder	☐ HIV/AIDS	☐ bleeding/clotting disorder
☐ diverticulosis	☐ hepatitis	☐ kidney disease	☐ seizure disorder
☐ cancer: type_____		☐ other: _____	

Detailed explanation:_____

Somerset Surgical Associates

Allergies:

□ Yes □ No

If yes, please list:_____

Your past surgical history: (check all that apply & indicate year)

□ appendectomy □ cholecystectomy □ hysterectomy

□ hernia repair □ breast surgery □ colon surgery

□ peripheral vascular surgery

□ heart: type_____ □ orthopedic: type_____ □ transplant: type_____

□ cancer: type_____ □ cosmetic: type_____

Detailed explanation or other surgery:_____

Your past hospitalization:

If any, please list the date and reason

Date:_____ Reason:_____

Date:_____ Reason:_____

Date:_____ Reason:_____

Family History: (check all that apply)

	Diabetes	High BP	Heart Problems	Stroke	Mental Illness	Cancer	Other
Grandfather							
Grandmother							
Father							
Mother							
Siblings							
Children							

Your social history:

Do you presently smoke tobacco? □ Yes □ No □ Former □ Thinking of quitting

How many per day?_____

Do you drink alcohol? □ Yes □ No How many drinks per week?_____

Do you smoke marijuana? □ Yes □ No Frequency_____

Use cocaine and/or heroin? □ Yes □ No Frequency_____

Other illicit drugs? □ Yes □ No Frequency_____

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Name: _____

Current Symptoms: (check all that apply)

General: ☐ weakness ☐ chills ☐ fever ☐ night sweats ☐ sleep disturbance

Allergy Immunology: ☐ current infection ☐ chronic steroid use

Eyes: ☐ double vision ☐ temporary loss of vision ☐ blurred vision

Endocrine: ☐ hot flashes ☐ cold intolerance ☐ excessive thirst

Respiratory: ☐ chronic cough ☐ shortness of breath at rest ☐ wheezing

Cardiovascular: ☐ chest pain with exertion ☐ palpitations ☐ shortness of breath

Gastrointestinal: ☐ constipation ☐ diarrhea ☐ exposure to hepatitis ☐ vomiting ☐ unexplained weight gain/loss

Hematology: ☐ anemia ☐ blood clot/deep vein thrombosis ☐ prolonged bleeding

Genitourinary: ☐ blood in urine ☐ frequent urination ☐ painful urination

Musculoskeletal: ☐ arthritis ☐ muscle aches ☐ painful joints

Skin: ☐ ulcers ☐ eczema ☐ keloid formation

Neurologic: ☐ dizziness ☐ fainting ☐ seizures

Psychiatric: ☐ anxiety ☐ depressed mood ☐ difficulty sleeping

Detailed explanation: _____

Somerset Surgical Associates

Payment Policy

To patients who have an insurance policy with which Somerset Surgical Associates participates:

All co-payments, co-insurances, and deductibles are the insured/patient's financial responsibility. Co-payments are due at the time of check-in. Any deductibles and co-insurances are to be collected prior to surgical procedures as determined by your insurance contract. Remaining balances not covered by the insured/patient's insurance company are due within 30 days from the time of service. For emergent procedures that took place prior to today, a minimum payment of $300 must be made towards the balance and a payment agreement must be signed for the remaining balance.

To patients who have an insurance policy with out-of-network benefits with which Somerset Surgical Associates DOES NOT participate:

All out-of-network fees are the insured/patient's financial responsibility and must be paid in full at the time of check-in. These charges will be submitted to the insurance company. If the insurance company fails to make payment, the insured/patient is held responsible for the full amount, including any additional charges.

To patients who are uninsured:

All office visits must be paid in full at the time of service. Planned procedures must be paid in full 1 week prior to the surgery date. For emergent procedures that took place prior to today, a $300 payment must be made towards the balance and a payment agreement must be signed for the remaining balance.

Applicable to all patients:

Any outstanding balances must be paid in full prior to any new appointments being made. Outstanding balances that are more than 60 days past due may be referred to an outside collection agency and will be subject to a collection fee of 25% of the outstanding balance. Patients who have been sent to collections will be discharged from the practice until the balance is paid in full with the collection agency.

Missed or Cancelled Appointments:

The office requires a 24-hour notice if an appointment needs to be canceled or rescheduled. Failure to provide notice will result in a $75 *No-show* fee.

Other Fees:

For any returned check, there will be a fee of $30 applied to the account.

If you have any questions about the payment policy, please feel free to contact our Billing Department.

Your name:_____ Signature:_____ Date:_____

Somerset Surgical Associates

Insurance Information

Primary Insurance

Insurance Company:_____

Insurance ID #:_____ Group #:_____

Subscriber Information

Subscriber Name_____ Relationship to Patient_____ Date of Birth_____

Home Phone #_____ Cell Phone #_____ Work #_____

Do you need an insurance referral for a specialist? _____Yes _____No

- If a referral is necessary and not presented at the time of your visit, you will be liable for the payment of your office visit.

Co-payment for specialist: $_____ Deductible: $_____

Secondary Insurance

Insurance Company:_____

Insurance ID #:_____ Group #:_____

Co-payment for secondary: $_____ Deductible: $_____

Workers Comp/Motor Vehicle Case

Is this a worker's compensation case? □ Yes □ No

Is this a motor vehicle case? □ Yes □ No

If yes, additional information is required. Please notify the receptionist for a relevant questionnaire.

Proof of Identity

Due to current insurance company policies and regulations, we are required to obtain a valid copy of your current health insurance card and photo ID at EACH and EVERY visit to our office.

If the insurance information you have provided is later found to be invalid or expired, you will be responsible for any and all payments for services provided at Somerset Surgical Associates.

Accepted Insurance Plans

Aetna • AmeriHealth • Cigna • Great West •Horizon/BCBS • Medicare • Oxford • United Healthcare

Out of network benefits with all other insurance carriers

As a courtesy, our office will submit all claims to the appropriate institutions and work diligently to obtain maximum reimbursement allowed by your policy.

Note that you will be responsible for all deductibles and/or co-insurances that apply to your outstanding claims.

I authorize the release of any medical or other information necessary to process my medical insurance claim. I authorize the payment of medical benefits to the physician. **If I am sent a payment directly from the insurance company for services my physician rendered, I promise to forward that check to Somerset Surgical Associates or face prosecution.**

Your name:_____ Signature:_____Date:_____

Somerset Surgical Associates

Authorization to Use and Disclose Health Information

I give the following individuals permission to discuss or to receive any medical documentation from this office.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature:_____Date:_____

I give permission to have messages left on my voicemail at the following telephone number(s):

Home: _____

Cellular: _____

Business: _____

SIGN BELOW IF YOU DECLINE TO SHARE YOUR MEDICAL DOCUMENTATION FROM THIS OFFICE WITH ANYONE OTHER THAN YOUR MEDICAL PHYSICIANS

Patient Signature:_____Date:_____

Sarah Bryczkowski, MD, FACS • Obi J Imegwu, MD, FACS
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