



1181 Orange Ave
Winter Park, FL 32789
Telephone 407-647-1331
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www.surgicalassoc.com

Roberto G. Posada, M.D.
Timothy C. Childers, M.D.
Thomas K. Mahan, M.D.

PATIENT INFORMATION

(Please Print) Today's Date _____ Male
Patient Name _____ Date of Birth _____ Age _____ Female
 Single Married
Street _____ City & State _____ Zip _____ Divorced Widow
Home Phone _____ Work Phone _____ Cell Phone _____
Social Security Number _____ Spouse or Guardian Name _____
Employer _____ Occupation _____
Employer Address _____
Spouse Employer _____
Do you have and Advance Directive (Living Will) No Yes (If Yes, please provide a copy.)

PERSON TO CONTACT IN CASE OF EMERGENCY _____

TELEPHONE NUMBERS _____

REASON FOR VISIT

What is your surgical problem? _____

What are your symptoms? _____ When did they start? _____

Primary Care Physician (Family Doctor) _____

Referring Physician _____ Other Physicians you are seeing _____

ASSIGNMENT OF BENEFITS

I assign insurance or other medical coverage benefits directly to Surgical Associates of Central Florida, PA. I understand that I am financially responsible for any services not covered by my third party coverage. All balances are due and payable on demand. I authorize the release of my medical records as necessary to complete my care.

Signature of Patient or Representative

Date

Printed Name



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Today's Date _____

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

Date of Birth _____

MEDICAL HISTORY

List Operations (Include Date) None Other Medical Conditions None

- 1) _____
- 2) _____
- 3) _____
- 4) _____

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Medications (State amount taken daily) None

Allergies (Please list below) None

- 1) Aspirin, Advil, Arthritis Medication No Yes
- 2) _____
- 3) _____
- 4) _____

Smoke No Yes _____ Packs/Day
 Alcohol No Occasional Moderate
 Drugs (recreational) No Occasional Moderate

HEALTH HISTORY

- | | | |
|--|---|---|
| Reactions to Anesthesia <input type="checkbox"/> No <input type="checkbox"/> Yes | AIDS <input type="checkbox"/> No <input type="checkbox"/> Yes | Constipation <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Headaches <input type="checkbox"/> No <input type="checkbox"/> Yes | Lung Disease <input type="checkbox"/> No <input type="checkbox"/> Yes | Diarrhea <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Stroke <input type="checkbox"/> No <input type="checkbox"/> Yes | Short Breath <input type="checkbox"/> No <input type="checkbox"/> Yes | Hemorrhoids <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Poor Vision <input type="checkbox"/> No <input type="checkbox"/> Yes | Seizures/Convulsions <input type="checkbox"/> No <input type="checkbox"/> Yes | Blood in Stools <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Hearing Loss <input type="checkbox"/> No <input type="checkbox"/> Yes | Alcoholism <input type="checkbox"/> No <input type="checkbox"/> Yes | Kidney Problems <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Depression <input type="checkbox"/> No <input type="checkbox"/> Yes | Arthritis <input type="checkbox"/> No <input type="checkbox"/> Yes | Frequent Urination <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Mental Illness <input type="checkbox"/> No <input type="checkbox"/> Yes | Cancer <input type="checkbox"/> No <input type="checkbox"/> Yes | Burning on Urination <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Nosebleeds <input type="checkbox"/> No <input type="checkbox"/> Yes | Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes | Number of times to Urinate
during the night _____ |
| Sore Throat/Cough <input type="checkbox"/> No <input type="checkbox"/> Yes | Gout <input type="checkbox"/> No <input type="checkbox"/> Yes | Rash <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Hoarseness <input type="checkbox"/> No <input type="checkbox"/> Yes | Liver Trouble <input type="checkbox"/> No <input type="checkbox"/> Yes | Varicose Veins <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Heart Trouble <input type="checkbox"/> No <input type="checkbox"/> Yes | Thyroid Trouble <input type="checkbox"/> No <input type="checkbox"/> Yes | Phlebitis <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Chest Pain <input type="checkbox"/> No <input type="checkbox"/> Yes | Stomach Ulcers <input type="checkbox"/> No <input type="checkbox"/> Yes | Are you Pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Abnormal Heart Beat <input type="checkbox"/> No <input type="checkbox"/> Yes | Poor Appetite <input type="checkbox"/> No <input type="checkbox"/> Yes | Last Menstrual Period _____ |
| High Blood Pressure <input type="checkbox"/> No <input type="checkbox"/> Yes | Chills/Fever <input type="checkbox"/> No <input type="checkbox"/> Yes | Other _____ |
| Bleeding Disorders <input type="checkbox"/> No <input type="checkbox"/> Yes | Nausea/Vomiting <input type="checkbox"/> No <input type="checkbox"/> Yes | Do you use a CPAP Machine? _____ |
| Anemia <input type="checkbox"/> No <input type="checkbox"/> Yes | Stomach Pain <input type="checkbox"/> No <input type="checkbox"/> Yes | |

