ABBEVILLE SURGICAL
CHRISTOPHER CERALDI, MD F.A.C.S
901 W. GREENWOOD ST SUITE 8B
ABBEVILLE SC, 29620
(864) 366-5345

IMPORTANT NOTICE
Due to HIPPA requirement, this form MUST be filled out completely
Please ask for help if you have questions about any field.
We will be UNABLE to file insurance for incomplete forms.

PATIENT INFORMATION

First Name:_____ Middle Initial: _____ Last _:_____

Social Security #:____-____-_____ Date of Birth:_____ Age:_____

Mailing Address: _____ City/ State:_____Zip Code:_____

Home Phone :( )_____ Cell Phone: ( )_____

Gender: _____ Race: _____ Marital Status: _____ Spouse Name: _____

Employment Status: Full Time Part Time Self Retired None Student Status:_____

Employer/School Name: _____ Work Phone#: _____

Employer Address: _____

Emergency Contact Information should not be someone living in the home with you:

Emergency Contact: _____ Phone _____

Family Physician: _____ Pharmacy Name:_____

HIPPA AUTHORIZATION ACCESS TO MEDICAL RECORDS

I authorize the following people to have access to my protective health information or medical information.
Please list the names and the relationship to you:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

INSURANCE INFORMATION

	Primary	Secondary	Tertiary
Subscriber(legal name)			
Telephone:			
Relation to pt:			
DOB:			
Social Security #:			
Employer:			
Address & Phone #:			
Insurance Company:			
Phone #:			
Subscriber ID #:			
Group #:			
Patient ID(if different):			

BENEFIT ASSIGNMENT AND RELEASE OF INFORMATION

I, the undersigned, for myself or a minor child or another person for whole I have authority to sign, certify that the insurance information listed above is correct and that all insurance benefits for services rendered are directly assigned to Abbeville Surgical. I understand that I am financially responsible for all charges regardless of benefits. I hereby authorize the release of information necessary to secure payment of benefits. I hereby authorize the release of information necessary to secure payment of benefits. I authorize the use of this signature on all insurance claim submissions. Should this account be turned over to a collection agency for collection, I understand and agree that I will be obligated to pay all collection costs, including, but not limited to, reasonable attorney fees.

_____ _____

SIGNATURE DATE

Patient Name: _____ Chart #: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

		YES	NO			YES	NO
HEART:	Heart Attack			**KIDNEY:**	Infection		
	High Blood Pressure				Stones		
	Irregular Heart Beat				Failure(Dialysis)		
	Chest Pain				Blood in Urine		
	CHF						
LUNGS:	Smoke			**VASCULAR:**	Circulation in Legs		
	Cough				Circulation in Arms		
	Short of Breath				Stroke		
	Emphysema/Asthma				Aneurysm		
	Cough up blood				Varicose Veins		
	COPD				Blood Clot		
BREAST:	Lump or Cyst			**NERVOUS:**	Loss of Movement		
	Pain				Numbness Arm/Leg/Face		
	Discharge				Speech		
	Change in Appearance				Vision		
	Family History Change				Dizziness		
					Syncope(black outs)		
ABDOMEN:	Hernia			**OTHER:**	Diabetes		
	Pain				Arthritis		
	Liver				Thyroid		
	Ulcer				Emotional Disorder		
	Gallbladder				Drink Alcohol		
	Blood in Stool				High Cholesterol		
	Vomiting blood				Rectal		
	Change in bowels				Hemorrhoids		
	Nausea/Vomiting				Lesions		

INFECTIOUS DISEASE: (circle) Hepatitis AIDS/HIV Other(please explain)

PLEASE NOTIFY YOUR DOCTOR AND MEDICAL STAFF IF YOU ARE CURRENTLY TAKING BLOOD THINNERS SUCH AS COUMADIN, PLAVIX, OR ARE ON AN ASPIRIN REGIMIN

MEDICATIONS (PLEASE LIST):

OPERATIONS:

ALLERGIES:

FAMILY HISTORY:

PHYSICIAN'S SIGNATURE DATE