M. SHANE DAWSON MD
GENERAL / LAPAROSCOPIC / ROBOTIC SURGERY

DEMOGRAPHIC INFORMATION

LAST NAME: ________________________________ FIRST NAME: _____________________________ MI: _______

DATE OF BIRTH: _____________________ WHAT IS YOUR GENDER: _____________________________________

WHAT SEX WAS RECORDED AT BIRTH? ___________________ PREFERRED PRONOUNS: ____________________

ADDRESS: ____ APT #: _______________________

CITY: _______________________________ STATE: ________________________ ZIP: ________________________

PREFERRED PHONE NUMBER: ______________________________________ HOME OR CELL

EMAIL: ____

RELATIONSHIP STATUS: ____ SINGLE ____ MARRIED ____ PARTNER ____ DIVORCED ____ WIDOWED

PREGNANT (CHECK IF APPLICABLE) ______ NURSING (CHECK IF APPLICABLE) ______

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? _____________________________________

EMERGENCY CONTACT INFORMATION

CONTACT FIRST AND LAST NAME: ____

CONTACT PHONE: __________________________________ RELATIONSHIP: ______________________________

CONTACT ADDRESS: ____

CITY: _______________________________ STATE: ________________________ ZIP: ________________________

By signing below, I attest that the information provided above is true and accurate

SIGNATURE OF PATIENT/ GUARDIAN: ___________________________________ DATE: ____________________

M. SHANE DAWSON MD
GENERAL / LAPAROSCOPIC / ROBOTIC SURGERY

PRIMARY INSURANCE

INSURANCE COMPANY: ____

MEMBER ID #: ____ GROUP #: _____________________________

(PROVIDE THE FOLLOWING INFO IF YOU ARE COVERED UNDER SOMEONE ELSE'S POLICY (spouse, parent, etc.)

INSURED'S FULL NAME: ____

INSURED'S DOB: ________________ RELATIONSHIP TO PATIENT: _____________________________________

ADDRESS: ____

CITY: _________________________ STATE: _______ZIP: __________ PHONE:___________________________

SECONDARY INSURANCE

INSURANCE COMPANY: ____

MEMBER ID #: ____ GROUP #: ____________________________

INSURED FIRST NAME: _________________________________ LAST NAME: __________________________

DOB: __________________RELATIONSHIP TO PATIENT: ____

ADDRESS: ____

CITY: _________________________ STATE: ________ZIP: ___________ PHONE: ________________________

EMPLOYMENT STATUS

____ EMPLOYED ____ UNEMPLOYED ____ FULL TIME STUDENT ____ RETIRED

OCCUPATION: ______________________________ BUSINESS NAME: ________________________________

By signing below, I attest that the information provided above is true and accurate

SIGNATURE OF PATIENT / GUARDIAN: _________________________________ DATE: __________________

NAME: ____ DOB: ______________________________

HEIGHT: ___________________ WEIGHT: _______________

MEDICAL HISTORY:

____

____

PAST SURGICAL HISTORY:

____

____

ANY HISTORY OF ANESTHESIA COMPLICATIONS (INCLUDING IN YOUR FAMILY)?

____

____

DO YOU HAVE A HISTORY OF ANY BLEEDING DISORDERS? YES NO

IF YES, PLEASE INDICATE: ____

DO YOU CURRENTLY SMOKE? YES NO

HAVE YOU EVER USED: _____ CIGARETTES OR E-CIGARETTES
_____ OTHER FORMS OF TOBACCO

DO YOU CURRENTLY DRINK ALCOHOL? YES NO

IF YES, PLEASE INDICATE HOW MANY DRINKS PER DAY: ____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? YES NO

IF YES, PLEASE INDICATE: ____

CURRENT MEDICATIONS AND DOSES: (BE SURE TO INCLUDE ANY ASPIRN OR BLOOD THINNERS)

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

(IF YOU TAKE NUMEROUS MEDICATIONS, PLEASE ATTACH A FULL LIST OF NAMES WITH DOSAGES)

DO YOU HAVE A PACEMAKER OR ANY CARDIAC STENTS/DEVICES?	YES	NO
ARE YOU ALLERGIC TO LATEX?	YES	NO
DO YOU HAVE A HISTORY OF SLEEP APNEA?	YES	NO
DO YOU HAVE A HISTORY OF HEART DISEASE?	YES	NO

RECENT X-RAY AND/OR LABORATORY STUDIES:

____

____

REFERRING PHYSICIAN: ____

ADDRESS: ____

PHONE: ______________________ FAX: ___________________________

PRIMARY CARE PHYSICIAN: ____

ADDRESS: ____

PHONE: ______________________ FAX: ___________________________

PHARMACY: ____

ADDRESS: ____

PHONE: ______________________ FAX: ___________________________

(THIS PHARMACY WILL BE USED SHOULD YOU NEED PRESCRIPTION MEDICATIONS FOR SURGERY)

_______________________________________ _____________________

SIGNATURE OF PATIENT/GUARDIAN REVIEWED BY:

MEMBER AUTHORIZATION FOR A DESIGNATED REPRESENTATIVE TO APPEAL A DETERMINATION

(Should your insurance deny your claim, this gives our office your permission to appeal the denial on your behalf.)

DATE: ___________________

MEMBER NAME: ____

MEMBER INSURANCE ID #: ____

I hereby authorize M. SHANE DAWSON, MD, PLLC to appeal the determination of ____ on my behalf, as my Designated

(Insurance Company Name)

Representative, and, as part of the appeal, I hereby authorize ____ in its decision letter and in connection

(Insurance Company Name)

with the processing of my appeal, to communicate with my Designated Representative concerning the following:

All medical and financial information contained in my insurance file, including but not limited to my treatment and hospital confinement in connection with the determination which is being appealed.

I understand this information is privileged and confidential and will only be released as specified in this Authorization. This authorization is valid for a period of one year

____
Signature of Member of Legal Guardian/Representative

____
Printed Name

AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATION

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by Dawson General Surgery in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health c are operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I AGREE AND CONSENT TO RELEASING MY HEALTH INFORMATION TO ME IN THE FOLLOWING MANNERS:

VIA EMAIL **PLEASE INITIAL**

_____ OK TO EMAIL TO THE ADDRESS LISTED ON PAGE 1 ____________

VIA POSTAL MAIL

_____ OK TO MAIL TO HOME ADDRESS ____________

VIA PREFERRED PHONE NUMBER

_____ OK TO LEAVE DETAILED MESSAGE ON PREFERRED PHONE # ____________

By signing below, I attest that the information provided above is true and accurate

SIGNATURE OF PATIENT / GUARDIAN: ________________________________ DATE: __________________