Samona Hand Surgery

Dr. Scott Samona, M.D.

Hand, Wrist, and Microvascular Surgeon

Patient Intake Form

NAME: ______________________________ DATE:______________

LAST FIRST MIDDLE

SSN: ☐☐☐ ☐☐ ☐☐☐☐ Date of Birth: / / GENDER: M / F / Other

MAILING ADDRESS: ______________________________

STREET CITY STATE ZIP CODE

PHONE: ______________ ______________ EMAIL ADDRESS: ______________

HOME CELL

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED/SEPARATED ☐ WIDOWED

Preferred Language: ☐ ENGLISH ☐ OTHER ______________

Race: ☐ White ☐ Black/African-American ☐ Hispanic/Latino ☐ American Indian/Alaskan Native ☐ Other______________ ☐ Decline

Emergency Contact (Name and Phone Number):

PRIMARY INSURANCE COVERAGE:

NAME OF CARRIER POLICY NUMBER GROUP NUMBER

SUBSCRIBER NAME AND RELATIONSHIP SUBSCRIBER DATE OF BIRTH

SECONDARY INSURANCE COVERAGE (if applicable):

NAME OF CARRIER POLICY NUMBER GROUP NUMBER

SUBSCRIBER NAME AND RELATIONSHIP SUBSCRIBER DATE OF BIRTH

GUARANTOR INFORMATION (IF UNDER 18):

(PERSON RESPONSIBLE FOR PAYMENTS) NAME PHONE

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HOW DID YOU LEARN ABOUT US, OR WHO REFERRED YOU?

INFORMATION SOURCE OR NAME OF REFERRER ______ PHONE ______

WHO IS YOUR PRIMARY CARE PHYSICIAN?

NAME OF PHYSICIAN ______ PHONE ______

STREET ______ CITY ______ STATE ______ ZIP ______

WHAT PHARMACY DO YOU USE?

NAME OF PHARMACY ______ PHONE ______

STREET ______ CITY ______ STATE ______ ZIP ______

I agree Samona Hand Surgery may request and use my prescription medication history from other healthcare providers, pharmacies, or third-party pharmacy benefit payers for treatment purposes.

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE: ______

PLEASE LIST ALL MEDICATIONS YOU CURRENTLY USE (if you have a list, please provide it to the check-in desk):

NAME	FREQUENCY	DOSAGE

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS? ☐ YES ☐ NO

IF YES, PLEASE LIST AND DESCRIBE YOUR REACTION TO THE MEDICATION (if you have a list, please provide it to the check-in desk):

MEDICINE ALLERGY	REACTION

ARE YOU CURRENTLY OR HAVE YOU EVER HAD PROBLEMS WITH THE FOLLOWING?

No Past Medical History		Heart Arrhythmia	
Anxiety Disorder		Heart Attack (MI)	
Asthma		HIV or AIDS	
Bleeding Disorder		Hypertension (High Blood Pressure)	
Blood Clots		Hypercholesterolemia	
Cancer: Type?		IBS (Irritable Bowel Syndrome)	
Congestive Heart Failure		Kidney Disease	
Coronary Artery Disease		Liver Disease	
COPD		Osteoporosis	
Diabetes Type I		Rheumatoid Arthritis	
Diabetes Type II		Stroke	
Fibromyalgia		Thyroid Disease (Hyper or Hypo)	
Gout		Tuberculosis (TB)	

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO IF YES, HOW MANY DRINKS/WEEK? ______________

DO YOU SMOKE? ☐ YES ☐ NO IF YES, PACKS/DAY? ______________ HOW LONG? ______________

FAMILY HISTORY

FAMILY MEMBER

FATHER	
MOTHER	
SIBLING	
SIBLING	
GRANDPARENT	
GRANDPARENT	

By signing below, I agree that all the information provided is true to the best of my knowledge. I also hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for the non-covered services. I also authorize the physician to release any information required to process this claim.

______________________________ ______________

PATIENT/REPRESENTATIVE SIGNATURE DATE