nsa Northwestern Surgical Associates

676N St Clair St
Suite 1525
Chicago, IL 60611

Supplemental Information Form

ADDITIONAL DEMOGRAPHIC INFORMATION:

Patient's Name ______________________

Patient's Age ______________________

Patient's Social Security Number ______________________

Patient's Address ______________________

City, State, Zip code: ______________________

Patient's Employer ______________________

Primary Insurance Carrier ______________________

Insurance Carrier Address ______________________

Policy Holder's Name ______________________

Policy Holder's Date of Birth ______________________

Subscriber ID Number ______________________

Group Number ______________________

Spouse's Name ______________________

Spouse's DOB: ______________________

Spouse's Number ______________________

Spouse's Employer ______________________

Emergency Contact Name ______________________

Emergency Contact Number ______________________

Emergency Contact Relationship ______________________

Referring Physician ______________________

Physician's Address ______________________

____

Physician's Number ______________________

Physician's Hospital Affiliation ______________________

____

How did you hear about NSA? ______________________

Email Address:

____

HISTORY OF PRESENT ILLNESS:

Reason for your visit: ______________________

____

Describe your symptoms: ______________________

____

____

____

Duration of symptoms: ______________________

Change in symptoms over time: ______________________

____

What makes symptoms better? ______________________

____

What make symptoms worse? ______________________

____

Are you taking medication for this problem? ______________________

____

____

FAMILY HISTORY:

Condition	Relation	Living?

Patient Signature ______________________

Today's Date ______________________

Office Use

Reviewed By: Date: / /

Northwestern Medicine

PATIENT PREOPERATIVE HISTORY

Name ______________________________ **DOB** __________

Preferred Daytime Phone #______________ **Preferred Language** ____________________

Planned surgery ____ **Today's Date** _______________

Surgeon _________________ **Primary Care Physician** ________________ **PCP Phone #**______________

Please list all previous surgeries (and approximate dates)

Please list any allergies to medications, latex, food or other (and your reactions to them)

List all medications (include over-the-counter drugs, inhalers, herbals, supplements and aspirin)

Drug Name	Dose and How Often?	Drug Name	Dose and How Often?
1.		7.	
2.		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	

Weight: (lbs or kg) __________ Height: (inches or cm) __________ (Circle the measurement units you use)

Please check any of the following that apply to your health:

- ☐ **Heart attack at any time***
- ☐ **Heart attack within past 60 days***
- ☐ **Chest pain or pressure with activity***
- ☐ **Angina***
- ☐ **Heart failure***
- ☐ **Heart surgery***
- ☐ **Heart stent in the last 6 months***
- ☐ **Heart stent at any time***
- ☐ **Atrial fibrillation***
- ☐ **Arrhythmia***
- ☐ **Congenital heart disease***
- ☐ Hypertension
- ☐ **Murmur***
- ☐ **Valve disorder***
- ☐ **LVAD***
- ☐ **Heart device***
- ☐ **Pacemaker***
- ☐ **Defibrillator***
- ☐ **Fainted in the last year***
- ☐ Pain in legs while walking
- ☐ None of these
- ☐ **Unable to climb 2 flights of stairs or walking 2 blocks because of chest pain or trouble breathing***

- ☐ **Oxygen at home***
- ☐ **Pulmonary hypertension***
- ☐ **Trouble breathing at rest or with minimal exertions***
- ☐ **Asthma***
- ☐ **COPD***
- ☐ **Pneumonia in last 2 months***
- ☐ **Any problems with your lungs***
- ☐ **Severe cough***
- ☐ None of these

Turn form over to complete 2nd page / see second page

*indicates the need for an in person preoperative evaluation.

Northwestern Medicine

Name ______________________________

- ☐ Face, arm or leg weakness
- ☐ **Stroke/TIA within past 3 months***
- ☐ Stroke or TIA at any time
- ☐ Paralysis
- ☐ Difficulty speaking
- ☐ **Dementia***
- ☐ Parkinson's
- ☐ **Myasthenia gravis***
- ☐ **Muscular dystrophy***
- ☐ **Multiple Sclerosis***
- ☐ **Spinal cord injury***
- ☐ **Brain tumor***
- ☐ **Brain aneurysm or AVM***
- ☐ **Epilepsy, blackouts or seizures***
- ☐ None of these

- ☐ **Hospitalized in last 30 days***
- ☐ Diabetes
- ☐ **Cancer: What type?__________***
- ☐ **Chemo or radiation last 3 months***
- ☐ **Kidney disease other than stones***
- ☐ **Liver disease***
- ☐ **Cirrhosis***
- ☐ **Lupus***
- ☐ Hepatitis B/C
- ☐ **Jaundice***
- ☐ **Hyperthyroidism***
- ☐ Hypothyroidism
- ☐ **Adrenal disorder***
- ☐ **Pituitary disorder***
- ☐ **Dialysis***
- ☐ **Scleroderma***
- ☐ **Rheumatoid arthritis***
- ☐ Sjogren's
- ☐ **HIV***
- ☐ **Use illegal drugs (excl. marijuana)***
- ☐ **Kidney failure***
- ☐ Taking antibiotics for any reason
- ☐ None of these

- ☐ **Blood thinners or anticoagulants other than aspirin***
- ☐ **Bleeding with surgery or tooth extractions***
- ☐ **Blood transfusion in last 3 months***
- ☐ **Blood clots/ Pulmonary embolus***
- ☐ **Hemophilia***
- ☐ **Von Willebrands***
- ☐ **Known bleeding disorder***
- ☐ **Jehovah's Witness / Refusal of blood products***
- ☐ **Sickle cell disease***
- ☐ **Anemia***
- ☐ Severe nose bleeds
- ☐ None of these

- ☐ **Malignant hyperthermia (in blood relatives or self) with anesthesia***
- ☐ **Severe nausea or vomiting from anesthesia***
- ☐ Difficult airway with anesthesia
- ☐ Dentures
- ☐ Problems opening your mouth
- ☐ Loose teeth
- ☐ None of the these

- ☐ **Unintentional weight loss > 10 lbs***
- ☐ Difficulty getting out of bed/chair by yourself
- ☐ Difficulty making your own meals
- ☐ Your physical abilities limit your daily activities
- ☐ Difficulty doing your own shopping
- ☐ Feel that everything you did was an effort: ____ days in the last week
- ☐ **Need assistance with eating or bathing or dressing***
- ☐ Fallen in the last 6 months (___ times)
- ☐ None of the these

- ☐ Very loud snoring
- ☐ Tired/fall asleep frequently during the day
- ☐ **Observed to stop breathing during sleep***
- ☐ High blood pressure/ Hypertension
- ☐ **Sleep apnea; NO CPAP***
- ☐ Sleep apnea; Uses CPAP
- ☐ None of these

- ☐ Cannot speak and/or understand English
- ☐ Cannot lie flat for 45 min
- ☐ Currently pregnant. Last menstrual period began:______
- ☐ Smoker (current or past) _____ packs/day for _____years. Quit date________
- ☐ Drink alcohol. How much each day? ______beers _____ glasses of wine ______shots of hard alcohol
- ☐ Deaf
- ☐ Blind
- ☐ None of these

Please list any medical illness or medications not noted already:

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*indicates the need for an in person preoperative evaluation.

Important Information
Billing and Cancellation Policies

New Patients require a valid credit card for confirmation. Urgent appointments will be offered on a first come, first served basis with a newly diagnosed cancer receiving top priority.

All patients are required to sign this agreement allowing us to charge your on-file credit card for any unpaid balances from your care or any cancellations at **2 (two) months after date of service.** This information will be kept in a secure location within the office, accessible to Dr. Davila, Dr. Fronza. Dr. Hartz, Dr. Toyama, Dr. Stryker, their Administrative Assistant, and our Billing Service. Any additional insurance payments to our office arriving after the bill has been paid in full will be sent directly to you as a refund within 72 hours.

Northwestern Surgical Associates participates in some health insurance plans and not in others. In plans which Northwestern Surgical Associates does not participate, services usually are covered as an "out-of-network" provider. This means different rules affect different rates of reimbursement, depending on the plan. **Please check with your individual health insurance plan for out of network benefits**. Co-payments with prior outstanding balances are payable at the time of your office visit. Cash, Checks and Credit Card are accepted.

Appointments

Cancellation of appointments must be made **at least 48 hours prior** to the time of your appointment to avoid being charged a **$50** cancellation fee per occurrence. This fee maybe waived the discretion of Dr. Davila, Dr. Fronza, Dr. Hartz, Dr. Toyama, and Dr. Stryker. Three or more clinic absences without appropriate notice will be cause for dismissal from the practice. This policy is intended to minimize "no shows" which inconvenience other patients as well as staff.

Procedures

There will be a **$100** charge for any missed procedures. Please notify the office **at least 48 hours prior** to your scheduled procedure date to cancel your procedure to avoid any fees.

Feel free to discuss any questions you have regarding these policies. Any charge for late cancellations or missed procedures are the sole responsibility of the patient; insurance companies will not cover these fees.

Acknowledgement of Billing and Cancellation Policy

By signing this Billing and Credit Card Authorization Form, I indicate that I fully understand the above billing and cancellation policy and agree to pay any co-payments, deductibles, co-insurance, non-covered services or amounts in excess of my policy's annual and/or lifetime maximum due. If the credit card on file is denied or no credit card is provided then the outstanding balances may be referred to an outside agency for further follow up, reported to the local credit bureau, and may result in legal proceedings. I will update the credit card information on file in any changes occur.

Credit Card Provided (Please circle): MASTERCARD VISA AMEX DISCOVER

Credit Card No: ____

Expiration Date: ______________ 3-digit code on back of card (4 on front of AMEX): ____________

Please Print Card Holder's Name: ______________________________________

Card Holder's Signature: ____________________________ Date:______________