



Patient Name	Date of Birth	Age	Sex	Height	Weight
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Social Security #	Address
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Number where you can be reached day before surgery	Home Phone	Work Phone	Cell Phone
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Person to contact in an emergency (WHO DOES NOT LIVE WITH YOU)	Relationship	Phone Number
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**1.) Medical History: (please circle any that apply to you)**

- |                          |           |                       |                      |           |
|--------------------------|-----------|-----------------------|----------------------|-----------|
| Heart                    | Diabetic  | Neurological Disorder | Back Problems        | Fainting  |
| High Blood Pressure      | Apnea     | Stroke                | Arthritis            | Seizures  |
| Chest Pain               | Asthma    | Psychiatric Disorders | Scoliosis            | Migrane   |
| Heart Murmur             | Emphysema | Glaucoma              | Birth Defect         | TB        |
| Congestive Heart Failure | Phlebitis | Bleeding Disorders    | Brain Damage         | Hepatitis |
| Mitral Valve Prolapse    | Lupus     | Sickle Cell Disease   | Cerebral Palsy       | Dialysis  |
| Hypoglycemia             | Cancer    | Gastric Ulcers        | Intestinal Disorders | HIV/AIDS  |
| Kidney Problems          | MS        | Seizure Disorder      | Hiatal Hernia        |           |

**2.) Have you had any recent respiratory infections, other types of infections or hospitalizations?**

No     Yes, please describe and date: \_\_\_\_\_

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**3.) Do you have any of the following? (please circle any that apply to you)**

- |                |                         |                  |                  |                  |
|----------------|-------------------------|------------------|------------------|------------------|
| Pacemaker      | Hip Replacement         | Artificial Limbs | Dentures/Partial | Use a Cane       |
| Difibrillator  | Knee Replacement        | Amputee          | Braces/Retainer  | Use a Walker     |
| Dialysis Shunt | Heart Valve Replacement |                  | Loose Teeth      | Use a Wheelchair |
| IV Catheter    | Heart Stents            |                  | Hearing Aid      |                  |
| Ostomy         |                         |                  | Contacts         |                  |

**4.) Do you have any other pertinent health information, concerns or history that would assist us in your care?**

No     Yes, please explain: \_\_\_\_\_

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5.) List all previous surgeries:

<u>Approximate Year</u>	<u>Type of Surgery</u>

6.) If female, date of last menstrual period: \_\_\_\_\_

7.) Have you, or any blood relative, ever had complications or reactions to anesthesia (delayed awakening, unexplained fever, MALIGNANT HYPERTHERMIA, vomiting, difficult intubation)?

No     Yes, please describe: \_\_\_\_\_

8.) Do you use:

Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount: _____
Tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount: _____
Caffeine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount: _____
Recreational Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount: _____

9.) Please list the name(s) of your current physician(s) (i.e. primary care physician, cardiologist, internist, pediatrician, orthopedist)

<u>Physician's Name</u>	<u>Specialty</u>	<u>Date of Last Visit</u>

I certify that my health history was reviewed and update by me on:

Today's Date	Patient Signature	Witness
Today's Date	Patient Signature	Witness
Today's Date	Patient Signature	Witness
Today's Date	Patient Signature	Witness
Today's Date	Patient Signature	Witness
Today's Date	Patient Signature	Witness

**NorthStar Surgical Center**

**Permission for Disclosure to Family, Friends, or Caregivers, and**

**Acknowledgment Of Receipt of Privacy Notice**

To Patient:

I acknowledge receipt of the Notice of Privacy Practices given to me by **Northstar Surgical Center**, and understand patient health information is protected and confidential. **Northstar** staff may discuss my health related matters with family, friends, caregivers or other designated persons, listed below.

Relevant health information may be shared with the following family members, other relatives, close personal friends, or other persons identified. Please mark applicable line and insert name of applicable person or persons.

_____	_____
Name	Relation
_____	_____
Name	Relation
_____	_____
Name	Relation
_____	_____
Name	Relation
_____	_____
Name	Relation
_____	_____
Name	Relation
_____	_____
Name	Relation

**Disclosure UPDATED by patient:**  
**Date and Initial of patient:** \_\_\_\_\_

\_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

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*If not signed, reason why acknowledgement was not obtained:* \_\_\_\_\_  
**Person seeking acknowledgement:** \_\_\_\_\_



NORTHSTAR SURGICAL CENTER

PATIENT INFORMATION

PATIENT NAME LAST NAME FIRST NAME M.I.

ADDRESS STREET CITY ZIP

SEX ( ) M ( ) F DATE OF BIRTH

SOCIAL SECURITY #

HOME PHONE: ( ) WORK PHONE: ( )

CELL PHONE: ( )

MARITAL STATUS: ( ) Single ( ) Married ( ) Divorced ( ) Legally Separated ( ) Widow

RACE: ( ) African American ( ) Caucasian ( ) Hispanic ( ) Asian ( ) Native American

OCCUPATION: EMPLOYER NAME:

ADDRESS:

GUARANTOR INFORMATION

RESPONSIBLE PARTY: LAST NAME FIRST NAME M.I.

ADDRESS: STREET CITY ZIP

SEX: ( ) M ( ) F DATE OF BIRTH

SOCIAL SECURITY #

HOME PHONE: ( ) WORK PHONE: ( )

CELL PHONE: ( )

MARITAL STATUS: ( ) Single ( ) Married ( ) Divorced ( ) Legally Separated

RACE: ( ) African American ( ) Caucasian ( ) Hispanic ( ) Asian ( ) Native American

OCCUPATION: EMPLOYER NAME:

ADDRESS:

INSURANCE INFORMATION

INSURANCE CO. NAME:

SUBSCRIBER (INSURED) ID#:

GROUP NAME: GROUP NUMBER:

SUBSCRIBER (INSURED) NAME:

INSURED DATE OF BIRTH: SEX: ( ) M ( ) F

INSURED SOCIAL SECURITY #: