Drs. Mark Tullos, Karen Ni-Jones, & Cara Govednik
Robin Sanders, RN, FNP-BC

50 Hillcrest Medical Blvd., Ste. 102
Waco, Texas 76712
Office Phone: (254) 202-7204 Office Fax: (254) 202-7298

Dear Patient,

Thank you for choosing our office for your specific surgical needs. Accompanying this letter, you will find the initial paperwork to be completed prior to your appointment date.

To help your visit go as smoothly as possible, we request that you bring the following items when you arrive for your visit with the physician:

- **Patients with insurance should bring their proof of insurance and the required co-payment amount. This amount may be paid by cash, check or credit card. We accept Visa, MasterCard, and Discover. We cannot break anything larger than a $50 bill.**

- **Insured patients who require referral authorizations for their visits should make arrangements with their primary care physician prior to arriving for their appointment.**

- **Patients without insurance coverage are welcome and should come prepared to pay for their office visit at the time of the appointment. New patients are required to pay $100 up front, and established patients are required to pay $50 up front. Office visit charges vary depending on the complexity of the service provided. If additional services are done in the office at the same time of the visit, you may be subject to additional charges.**

Please bring your completed paperwork, all insurance cards, a list of medications, and the payment for your office visit to your scheduled appointment.

We want to make your visit as pleasing and stress free as possible. If you have any questions, please feel free to call our office at (254) 202-7204.

We look forward to helping you in any way that we can.

Sincerely,

Hillcrest General Surgery

Name: _____ DOB: _____

Reason for visit: _____

Review of Systems

Are you **currently** experiencing any of the following?
(Please circle all that apply)

Constitutional	Fatigue, fever, chills, body aches, weight loss, weight gain, loss appetite
Eyes	Double vision, blurred vision, peripheral vision changes, sudden changes in vision
Head/Ears/Nose/Throat	Headaches, vertigo, neck stiffness, neck pain, sinus problems, hearing loss, ringing in ears, hoarseness, difficulty swallowing
Breast	Lumps, tenderness, swelling, nipple discharge
Cardiovascular	Chest pain, irregular heartbeats, lower extremity swelling
Respiratory	Shortness of breath, wheezing, cough
Gastrointestinal	Nausea, vomiting, diarrhea, constipation, abdominal pain, loss of bowel control
Genitourinary	Urgency, frequency, painful urination, getting up often at night to urinate, loss of bladder control
Rectal	Loss of bowel control, rectal mass, hemorrhoids, rectum protruding out
Skin	Rash, itching, new skin lesions, jaundice (yellow skin)
Neurologic	Muscular weakness, incoordination, tingling/numbness, memory difficulties, speech difficulties, seizures, loss of balance
Musculoskeletal	Joint pain, joint swelling, muscle pain, limitation of motion, muscle cramps, muscular weakness, back pain, gait disturbances
Endocrine	Excessive urination, excessive thirst, enlarged hands and feet, enlarged facial features
Psychiatric	Anxiety, depression, hallucinations, difficulty sleeping
Hematologic	Easy bleeding, easy bruising, previous blood transfusion
Allergic/Immune	Sinus allergy symptoms, latex allergy
Other *List any other symptoms not listed	

Hillcrest Physician Services

50 Hillcrest Medical Blvd, Suite 102
Waco, TX 76712

Baylor Scott & White
HILLCREST MEDICAL CENTER
WACO

Please complete all forms fully and to the best of your ability. If something does not apply to you, please write *N/A* in the field.

Patient Demographics:

Name: _____
Address: _____
Apt: _____ City: _____
State: _____ Zip: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Date of Birth: _____
Social Security Number: _____

Sex: Male Female
Marital Status: Married Single Divorced Widowed Minor
Race: White American Indian/Alaska Native Asian Black/African American Other Declined
Ethnicity: Hispanic/Latino Not Hispanic/Latino Declined
Employment Status: Employed Unemployed Retired Student Minor
Employer: _____
Primary Doctor: _____
Referring Doctor: _____

***Emergency Contacts* (person you are giving us permission to release your health information to):**

Name: _____
Relationship to Patient: _____
Phone: _____

Name: _____
Relationship to Patient: _____
Phone: _____

***Guarantor* (where the bills will be sent if not self):**

Name: _____
Address: _____
City: _____
State: _____ Zip: _____

Date of Birth: _____
Social Security Number: _____
Relationship to Patient: _____
Phone: _____

***Primary Insurance Information*:**

Insurance Company: _____
ID Number: _____
Group Number: _____

Cardholder Name: _____
Date of Birth: _____
Social Security Number: _____
Relationship to Patient: _____

***Secondary Insurance Information*:**

Insurance Company: _____
ID Number: _____
Group Number: _____

Cardholder Name: _____
Date of Birth: _____
Social Security Number: _____
Relationship to Patient: _____

PATIENT NAME: _____ DOB: _____

PATIENT MEDICAL HISTORY (check all that you currently have and/or have previously had)

HEART PROBLEMS
- ☐ Congestive Heart Failure
- ☐ Deep Vein Thrombosis
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Neuropathy (numbness/tingling in legs)
- ☐ Irregular Heartbeat
- ☐ Other: _____

NEUROLOGICAL
- ☐ Alzheimer's Disease
- ☐ Parkinson's Disease
- ☐ Migraines
- ☐ Seizure Disorder
- ☐ Stroke
- ☐ Dementia
- ☐ TIA
- ☐ Other: _____

GASTROINTESTINAL
- ☐ Cirrhosis
- ☐ Gastric Ulcer
- ☐ GERD (acid reflux)
- ☐ Rectal Bleeding
- ☐ Hemorrhoids
- ☐ Diverticulitis
- ☐ Other: _____

ENDOCRINE PROBLEMS
- ☐ Diabetes Type I (Juvenile)
- ☐ Diabetes Type II (Adult Onset)
- ☐ Hyper/Hypothyroid Disorder
- ☐ Hyper/Hypocalcaemia
- ☐ Other: _____

URINARY PROBLEMS
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Prostate Enlargement
- ☐ Other: _____

LUNG PROBLEMS
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Pulmonary Embolism
- ☐ Sleep Apnea
- ☐ Other: _____

MUSCULOSKELETAL
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis

INFECTIONS
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV +
- ☐ Other: _____

CANCER (type, stage, and location)
- ☐ _____
- ☐ _____

FAMILY MEDICAL HISTORY (please list medical conditions and/or cause of death)

Mother: _____

Father: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

Siblings: _____

Children: _____

SURGICAL HISTORY (please list all previous surgeries, year performed, and surgeon)

_____

_____

_____

_____

_____

_____

SOCIAL HISTORY

Marital Status: _____

Number of children: _____

Occupation: _____

FEMALE PATIENTS ONLY

Are you currently pregnant? Yes No

Date of your last period: _____

Age of menopause: _____

SUBSTANCE USE (past and present)

Tobacco: Yes/No **If Yes:** Amt/Week _____ Age started/stopped _____

MEDICATION LIST

(Please include all prescriptions, over-the-counter medications, vitamins, and herbal supplements)

Medication	Dose	Times Per Day	Reason for Taking

ALLERGIES

Check if you are allergic to the following:

Penicillin:_____ Codeine:_____ Sulfa Drugs:_____ Latex:_____ Iodine:_____

Please list all other foods and medications you are allergic to and your reaction to them:

Allergy	Reaction

Hillcrest Physician Services

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Narcotics/Controlled Substances Prescription Notice

Our office does not prescribe narcotics on a long term basis, nor do we administer narcotics by injection at the clinic. No narcotic medications are kept on site. Individuals who are seeking "pain killers" for chronic use are hereby advised to seek treatment with an appropriate pain management clinic or, if the pain is severe, with the local emergency department. Narcotic prescriptions will not be refilled after office hours or on weekends.

It is an inherently dangerous practice to receive prescriptions for narcotics and other controlled substances from several physicians at the same time. Therefore, patients who do seek narcotic prescriptions through our office agree that, unless otherwise indicated by our physicians, we are to be the sole prescribing physicians for the patient. Furthermore, patients desiring prescriptions from our clinic agree to grant us permission to contact pharmacies and other physicians in order to ensure compliance with this policy. If we determine that multiple physicians are ordering prescriptions for pain medications, we will immediately cease all orders for such treatments from our office.

Prescription Policy

- The patient will be given a choice to designate a pharmacy to be used (see signature page). All prescriptions should then be filled through this pharmacy only.
- We ask that you contact your designated pharmacy for all refill requests even if you have no refills remaining. Please allow for a 48 hour turnaround time on all prescriptions.
- We do not refill prescriptions on weekends or holidays. Be sure to submit your request before 2:00pm on Thursday for prescriptions you will be out of over the weekend.
- We do not prescribe medications prior to surgery. Patients must contact their primary care or referring provider.
- We will not refill prescriptions for patients not seen in the past 30 days by a provider in our office.
- We will not refill prescriptions for patients who have missed appointments until you are seen by one of our providers.
- Prescription requests submitted after 2:00pm will not be called in until the next business day.
- Medications will only be called into the designated pharmacy.
- Medications are to be taken according to directions. No early refills will be granted.
- It is the patient's responsibility to keep medications safe. Lost or damaged medication may not be refilled. If medication is stolen, you must file a police report and submit the number for verification to our office.

Nicotine Policy

Impact of nicotine on surgical healing:

- There is ample evidence in research literature that the presence of nicotine (chewing tobacco, snuff, dip, cigarette or cigar smoking, nicotine patches or any other tobacco product) will significantly impair healing.
- Any amount of nicotine in your bloodstream hurts your body's ability to heal properly.
- Nicotine slows the blood flow to your bones more than any other tissue in your body, starving bone of its ability to heal any fractures
- To aid in a favorable surgical outcome, it is recommended that use of all nicotine and nicotine cessation aids that contain nicotine, such as nicotine gum or nicotine patches, are stopped while your body heals.

CONSENT FOR MEDICAL CARE

AUTHORIZATION FOR EXAMINATION AND TREATMENT: I authorize the examination and/or treatment considered necessary, and that the treatments and procedures will be performed by the physicians and/or nurse practitioners of Hillcrest Physician Services. Authorization is hereby granted for such treatments, procedures, administration of local anesthetics, medications, or other treatments as deemed reasonable and medically necessary for care.

ASSIGNMENT OF BENEFITS

INSURANCE BENEFITS: I authorize Hillcrest Physician Services to furnish any information to my insurance company in order to process my claim, including release of medical records as necessary. I understand that my insurance coverage is a contract between myself and the insurance, and I acknowledge that co-payment, deductible, and co-insurance amounts are due at time of service, as stated in my health insurance agreement.

NOTICE OF NON-COVERAGE: I understand that in the event of non-coverage, I am responsible for payment, at time of service, to Hillcrest Physician Services for any service or item provided during treatment. Non-coverage would include uninsured patients, failure to provide proof of insurance coverage, or any services or items not covered by your insurance.

TELEPHONE CONSUMER PROTECTION ACT: I agree, in order for you to service my account or to collect monies I may owe, Hillcrest Physician Services and/or their agents may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. They may also contact me by sending text messages or emails, using any email address I provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

PAPERWORK: Various paperwork, including but not limited to disability and FMLA forms, may need to be filled out by your physician. If required by your physician, a $25 charge **per set** is due when we receive the paperwork, and we require 48 hours for completion. Many forms cannot be fully completed until after surgery.

PATIENT PRIVACY AND RIGHTS

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been made aware and offered a copy of the Hillcrest Health System's Notice of Privacy Practices related to the handling of patients' private health information.

PATIENT RIGHTS: I understand that I have the right to participate in my plan of care and treatment. I have the right to refuse treatment and be informed of the consequence of such refusal.

ACKNOWLEDGMENT OF PRESCRIPTION AND NICOTINE POLICIES

I have read and understand the policies of this office regarding prescriptions and nicotine use. I agree to the terms involved in the Prescription and Nicotine Policies and have received a copy of these policies.

Designated Pharmacy (name and location): _____

_____ _____

Patient/Guarantor Signature **Today's Date**

_____

Relationship to Patient