Monterey County Surgical Associates

General, Vascular, Thoracic, ENT, Bariatric Surgery and Advanced Laparoscopic Surgery
Website: montereysurgery.com
2 Upper Ragsdale Drive, Suite B 230 Monterey, CA 93940
Phone: (831) 649-0808
Fax: (831) 649-8795

Office Hours: 9:00am-5:00pm (Monday-Friday)

Your First Appointment

We thank you for choosing Monterey County Surgical Associates. Here is a list of what to bring with you to your first appointment.

- Health Questionnaire completed
- Contact information completed
- Medication List
- Remember to bring any additional paperwork with you that might pertain to your visit, including outside records
- A list of questions- this helps to avoid the tendency we all have to forget to ask questions when we are at the doctor's office
- Insurance cards

Please visit our website at www.montereysurgery.com

If you have any questions, please call us at (831) 649-0808

Please arrive 15 minutes early to your appointment

Thank you

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Map & directions

From the Coast (Highway 1): about 3.3 miles, 10 minutes

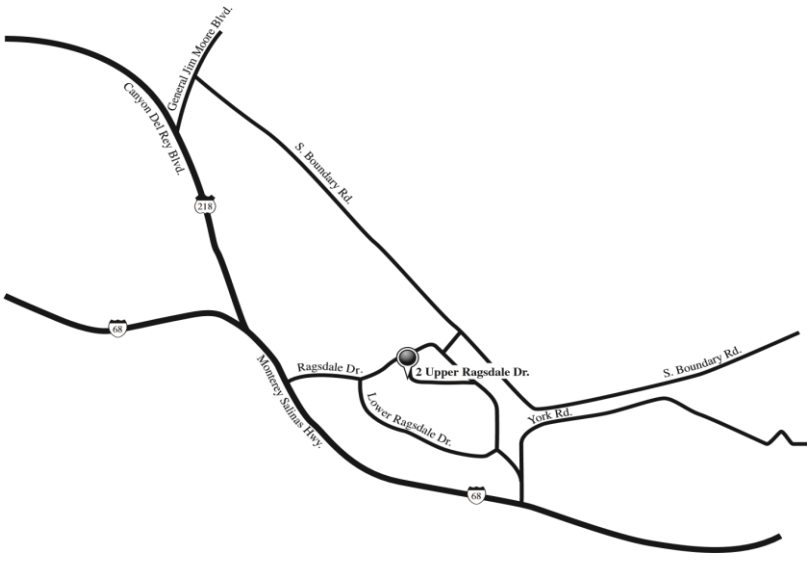
- Turn onto **Highway 68 East** (Toward Salinas)
- Travel 3.3 miles, past the airport and Canyon Del Ray Professional Complex (stoplight)
- Turn left onto **Ragsdale Drive** (stoplight) at Ryan Ranch
- Travel uphill through one stop sign (Lower Ragsdale Drive)
- Take the second right beyond the stop sign into the **Ryan Ranch Medical Campus, West Entrance.**
- Take the 1st, 2nd or 3rd drive to the left to access parking. We are the first big office building that you will see on your left.

From Salinas: about 20 minutes, 13 miles

Take **Highway 68 West** (toward the ocean)

- Take **Highway 68 West** (toward the ocean)
- Travel about 13 miles, past York School and past the first entrance to Ryan Ranch.
- Turn right onto **Ragsdale Drive** (stoplight) at Ryan Ranch
- Travel uphill through one stop sign (Lower Ragsdale Drive)
- Take the second right beyond the stop sign into the **Ryan Ranch Medical Campus, West Entrance**.
- Take the 1st, 2nd or 3rd drive to the left to access parking. We are the first big office building that you will see on your left.

Google Map our location: https://goo.gl/maps/rXoQf8BPjaR2



MCSA Monterey County Surgical Associates

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____
Birthdate: _____ Gender: ____ Social Security #: _____ Email Address: _____
Marital Status: Single Married Divorced Widowed Other: _____
Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____
__ Check this box if it is NOT okay to leave detailed voicemail messages at the phone numbers provided above.
Mailing Address: _____ Zip: _____ City: _____ State: _____
Primary Language: _____ Race: _____ Ethnicity: _____
Preferred Pharmacy: _____ City: _____ Street: _____

If Patient Is A Minor Please Complete

Name of Parent/Guardian: _____ Guarantor Date of Birth: _____
Mailing Address: _____ Zip: _____
City:_____ State: _____ Phone: (____) _____
Social Security #: _____ Relationship to Patient: _____

Primary Insurance Information

Name of Insured: _____ Date of Birth: _____ Social Security #: _____
Relationship to Insured: _____ Insurance Address: _____
Zip: _____ City: _____ State: _____
Insurance Carrier Name: _____ Policy/Group #: _____

Secondary Insurance Information

Name of Insured: _____ Date of Birth: _____ Social Security #: _____
Relationship to Insured: _____ Insurance Address: _____
Zip: _____ City: _____ State: _____
Insurance Carrier Name: _____ Policy/Group #: _____

Person to Notify in Case of Emergency

Name (Not in Same Household): _____ Street Address: _____
Zip: _____ City: _____ State: _____
Home Phone: (____) _____ Relation to Patient: _____

Employer Information (If Patient Is A Minor, Parent/Guardian, Please Complete)

Employer Name: _____ Occupation: _____
Street Address: _____
Zip: _____ City: _____ State: _____ Employer's Phone: (____) _____

We request payment at time of service. We are contracted with some insurance carriers and may be able to bill directly for you. Please provide us with a copy of your insurance card. If co-payment/deductible is part of your plan, we request that your portion is paid at the time of service. I hereby authorize the release of medical information to insurance carriers needed to process a claim and request payment is issued directly to BENNER, GARZA, HYDE, LURIE, STUNTZ, VERLENDEN, CHANG, VIERRA and KEIR-GARZA (d.b.a MONTEREY COUNTY SURGICAL ASSOCIATES) for medical service rendered. I understand that I am financially responsible for all charges whether or not covered by insurance, and that I will be expected to pay if insurance has not paid within 60 days. Monterey County Surgical Associates may add a monthly rebilling fee for overdue balances. I hereby consent to treatment at Monterey County Surgical Associates.

By providing my phone/email address, I give Monterey County Surgical Associates permission to call/email me directly or through a third party to survey me regarding my visits for the purpose of patient satisfaction and quality assessment or appointment confirmation. Monterey County Surgical Associates will not share my phone/email address or medical records with others.

Signature: _____ Relationship: _____ Date: _____

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Date: _____

Acknowledgemenet of Privacy Practices

I hereby acknowledge that I received a copy of this medical office's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate your relationship with the patient:

__ Parent or guardian of minor patient
__ Guardian or conservator of an incompetent patient
__ Beneficiary or personal representative of deceased patient

I identify the following individuals as being involved in my care and/or payment of my care. I authorize my healthcare provider, or representative, to discuss any healthcare and/or financial information with the following individuals.

Name	Relationship	Phone

Patient Name: _____
DOB: _____

Signed: _____ Date: _____

Privacy Official, 100 Wilson Rd, Ste 100, Monterey, CA 93940

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General Health Questionnaire

This is a confidential record of your medical history and will help us to provide the best care possible. Information contained here will not be released to any person unless authorized by you.

Patient Name: _____ Age: _____ DOB: _____

Referring Doctor's name, address and phone number: _____

_____

_____

Other Doctors' names who care for you – include address and phone numbers:_____

_____

_____

What medical condition brings you to the office today?

_____

_ ALLERGIES or REACTIONS TO MEDICATIONS/FOODS/OTHER AGENTS:

Allergic to	Reaction or Side Effect

__ No Known Drug Allergies

MEDICATIONS: All medications that do and do not require a prescription

Medication	Dose	Times per day

Please use an additional blank page to list more medications.

What is your preferred pharmacy?

_____

__ I do not currently take any medications

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PERSONAL MEDICAL HISTORY:

Please indicate whether you have had any of the following medical problems:

__ Angina
__ Heart failure
__ Artificial Heart Valve
__ High blood pressure
__ Irregular heart rhythm
__ History of heart attack
__ High cholesterol
__ High triglycerides
__ Emphysema
__ COPD
__ Other lung problems _____
__ Asthma
__ History of venous thrombosis
__ History of embolus

__ Hepatitis A B C (circle one)
__ HIV / AIDS (circle one)
__ Cancer (specify type) _____
__ Alzheimer's
__ Dementia
__ Abnormal bleeding/bruising(describe)
_____
__ Anemia
__ Thyroid problems
__ Rheumatoid arthritis
__ Serious depression
__ Other psychiatric illness
__ Alcoholism
__ Headaches
__ TMJ

__ Sleep apnea CPAP _Y/ _N
__ Stroke
__ Seizure
__ Epilepsy
__ Diabetes
__ Kidney disease
__ Bladder problems
__ Liver problems
__ Enlarged prostate
__ Glaucoma
__ Problems w/ Anesthesia
Other:_____
_____
_____
_____

Have you ever had a blood transfusion? __ Yes __ No
Would you agree to receive a blood transfusion if it were necessary for your health? __ Yes __ No
If you have taken steroids (prednisone or cortisone) in the last 6 months, please indicate the date_____

SURGICAL HISTORY List any previous operations you have had:

Operation	Date	Type of Anesthesia and noted problems?

List any hospitalizations you have had for any illness not requiring surgery:

Hospitalizations	Date

Do you currently smoke tobacco? (choose one):

__ I have no history of tobacco use.

__ No – I smoked in the past but quit (when?)_____ and I smoked ____ packs/day for_____ years. I last smoked_____.

__ Yes: I smoke now and have smoked _____ packs per day for _____ years.

__ Are you interested in quitting? __ Yes __ No

Do you drink alcohol?

__ Yes, more than 7 drinks per week. How many?____

__ Yes, less than 7 drinks per week. How many?______

__ I used to, but no longer drink because: _____

__ I have no history of alcohol use.

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Do you currently use other drugs? __ Yes __ No. Describe:_____

What is the heaviest physical activity you might do in a week? _____
With whom do you live? _____
What is your Occupation? _____
What hobbies are important to you? _____
Are you a primary caregiver? __ Yes __ No If yes, who? _____
Could someone care for you if you were seriously ill? __ Yes __ No If yes, who? _____

FAMILY HISTORY Do any of your blood relatives have the following problems?

Disease Name	Mother	Father	Sister	Brother	Son	Daughter	Describe
Alcoholism							
Breast Cancer							
Colon Cancer							
Ovarian Cancer							
Other Cancer (type)							
Diabetes							
Liver Disease							
Heart Disease							
Kidney Disease							
Lung Disease							
Rheumatoid Arthritis							
Serious Mental Illness							
Anesthetic problems							
Stroke							
Problem with Anesthesia							
Pulmonary Embolus							
Bleeding disorder							
Other serious illness							

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REVIEW OF SYMPTOMS Please indicate which symptoms you are currently experiencing.

General Symptoms
__ Recent fever
__ Night sweats
__ Recent weight loss > 10 lbs
__ Recent weight gain > 10 lbs
__ Fatigue

Eyes
__ Contact lenses
__ Yellowing of the eyes

Vision changes

Ears/Nose/Throat
__ Hearing loss
__ Blood in sputum
__ Choking while swallowing
__ Food gets stuck while swallowing
__ Nose Bleeds

Cardiovascular
__ Chest pains
__ Palpitations
__ Swollen ankles or feet

Respiratory
__ Chronic Cough
__ Shortness of breath
__ Heavy Snoring
__ Stop breathing while sleeping

Gastrointestinal
__ Heartburn
__ Nausea
__ Vomiting
__ Diarrhea
__ Black or tarry stools
__ Constipation
__ Acid Reflux

Genitourinary
__ Painful urination
__ Difficulty urinating
__ Pregnant
__ Blood in urine

Musculoskeletal
__ Difficulty walking
__ Joint pain or arthritis
__ Back pain

Skin
__ Recent change in mole or birthmark
__ Breast mass, discharge, skin dimpling
__ Non-Healing wounds

Neurological
__ Weakness of one arm or leg
__ Fainting or Blackouts
__ Memory loss
__ Confusion
__ Fall in last 3 months?

Blood/Lymphatic
__ Excessive bleeding
__ Easy bruising

Psychiatric
__ Serious Depression
__ Panic attacks

Other Symptoms:_____
_____
_____
_____

Questions to remember to ask:_____
_____
_____
_____