1. PATIENT INFORMATION *All patients complete this section.*

NAME (LAST, FIRST, M.I.)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX
			M F
MAILING ADDRESS	CITY	STATE	ZIP CODE
STREET ADDRESS	CITY	STATE	ZIP CODE
EMAIL ADDRESS	HOME PHONE	STUDENT STATUS □ N/A	
		□ PART TIME	□ FULL TIME
EMPLOYER	WORK PHONE	MARITAL STATUS	
		□ SINGLE	□ MARRIED
OCCUPATION	CELL PHONE	□ DIVORCED	□ WIDOWED
RACE / RELIGION / NATIONALITY / LANGUAGE		□ LEGALLY SEPARATED	□ OTHER

2. FINANCIAL RESPONSIBILITY *If the person responsible for payment is someone other than the patient, complete this section.*

NAME (LAST, FIRST, M.I.)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX
			M F
MAILING ADDRESS	CITY	STATE	ZIP CODE
STREET ADDRESS	CITY	STATE	ZIP CODE
EMAIL ADDRESS	HOME PHONE	CELL PHONE	
EMPLOYER	SUPERVISOR	WORK PHONE	
OCCUPATION	RELATIONSHIP TO PATIENT		

3. INSURANCE COVERAGE *If the patient has insurance coverage, complete this section.*

PRIMARY INSURANCE COMPANY	***SECONDARY*** INSURANCE COMPANY

4. INSURANCE POLICY HOLDER *If the policy holder is someone other than the patient or the person listed as financially responsible for payment, complete this section.*

PRIMARY POLICY HOLDER NAME (LAST, FIRST, M.I.)				***SECONDARY*** POLICY HOLDER NAME (LAST, FIRST, M.I.)			
SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX		SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	
		M	F			M	F
HOME PHONE	CELL PHONE			HOME PHONE	CELL PHONE		
PATIENT'S RELATIONSHIP TO THE SUBSCRIBER?				PATIENT'S RELATIONSHIP TO THE SUBSCRIBER?			
EMPLOYMENT STATUS	EMPLOYER			EMPLOYMENT STATUS	EMPLOYER		
EMPLOYER ADDRESS				EMPLOYER ADDRESS			

I have received Laurel Surgery & Endoscopy Center's patient brochure containing information regarding pre-operative instructions, patient rights & responsibilities, advanced directives, and facility ownership.

PATIENT STICKER

_____

Patient/Responsible Adult Signature Date

We are pleased that you and your doctor chose our center for your procedure. As we strive to provide exceptional care with compassion, our patients and visitors are the highest priority. There are two ways in which you can provide feedback which can help us improve services in the future.

First, we would like to check on you after your procedure and plan to call you on the first business day after your discharge. Please indicate below if you would like to be contacted and what number would be best.

□ No, I prefer not to be contacted.

□ Yes, please contact me at this number: _____

Second, your input regarding the service you received at our facility is very important to us, for this reason we ask that you complete a patient satisfaction questionnaire at your convenience. A questionnaire will be sent to the e-mail address provided below and Laurel Surgery & Endoscopy Center will not share this e-mail address with any third party. If you prefer, we also offer printed questionnaires with pre-paid return postage. Please indicate your preference below.

□ Send a questionnaire to this e-mail address:

_____

□ Provide me with a printed questionnaire.

We value your opinion and wish you a healthy future.

NOTICE OF PRIVACY PRACTICES

This notice describes how Laurel Surgery & Endoscopy Center, LLC (LSEC) can use and/or disclose your health information and how you can access this information. This notice applies to all of your health information on file at our facility. Please review it carefully.

Health information is recorded both in a paper chart and on computers. These are your medical records. All medical records are the property of LSEC but the information in the records belongs to you. LSEC protects the privacy of your health information. The law allows LSEC to use or disclose your health information for the following purposes: to provide treatment; to obtain payment; to communicate with family/caregiver; to comply with local, state and/or federal laws.

Except as described in this notice, LSEC will not use or disclose your health information without your written authorization. If authorization is given, it may be revoked in writing at any time. In regard to your protected health information, you have the right to: request a change of the means/location for receiving your health information; request personal inspection of your health information; request a copy of your health information; request that incorrect or incomplete health information be amended; request an accounting of disclosures of your health information; request a restriction on the information we disclose about you for history, payment or healthcare operations; request a change in the authorization for individual/caregiver access to protected health information.

Please submit in writing, all request and/or complaints to:

Laurel Surgery & Endoscopy Center, LLC
Privacy Officer
1710 West 12th Street
Laurel, MS 39440

LSEC reserve(s) the right to amend this Notice of Privacy Practices at any time in the future, and to make new provisions effective for all information that it maintains, present or past.

AUTHORIZATION FOR INDIVIDUAL/CAREGIVER ACCESS

Laurel Surgery & Endoscopy Center, LLC Privacy Practices is in place to protect and enhance patient privacy rights with respect to their health information. By listing the below individual(s), you are giving Laurel Surgery & Endoscopy Center, LLC permission to release, whether verbal or written, your protected health information to the individual(s)/caregiver(s). Protected health information includes but is not limited to appointment times/dates, insurance information/payments.

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

This authorization is NOT a power of attorney nor does it allow any individual to make decisions regarding your healthcare.

Patient Name _____

Signature_____Date_____

Laurel Surgery & Endoscopy Center LLC

PATIENT SUMMARY – Medical History

Date: _____ Patient Name: _____ Gender: □ M □ F

Primary Care Physician/Clinic: _____ DOB: _____

DIAGNOSES & CONDITIONS	ONSET	DIAGNOSES & CONDITIONS	ONSET

If you have never had a surgical procedure, initial here → _____ Otherwise, list all procedures below.

SURGICAL PROCEDURES	DATE	SURGICAL PROCEDURES	DATE

REVIEW Date & initials indicate my review as patient and/or responsible adult.

DATE					
INITIALS					
DATE					
INITIALS					

Patient Sticker

Laurel Surgery & Endoscopy Center LLC

PATIENT SUMMARY – Adverse Reactions

Date: ________________ Patient Name: ____________________________________ DOB: ________________

If you have never had an adverse reaction to any medication, food, or other substance, initial here → ________

Otherwise, list medications, foods, or other substances that have caused you to have an adverse reaction.

Medication/Food/Substance	Adverse Reaction
	□ itching □ rash/hives □ difficulty breathing □ swelling of: ______________________________ □ nausea/vomiting □ bleeding □ other: ____
	□ itching □ rash/hives □ difficulty breathing □ swelling of: ______________________________ □ nausea/vomiting □ bleeding □ other: ____
	□ itching □ rash/hives □ difficulty breathing □ swelling of: ______________________________ □ nausea/vomiting □ bleeding □ other: ____
	□ itching □ rash/hives □ difficulty breathing □ swelling of: ______________________________ □ nausea/vomiting □ bleeding □ other: ____
	□ itching □ rash/hives □ difficulty breathing □ swelling of: ______________________________ □ nausea/vomiting □ bleeding □ other: ____
	□ itching □ rash/hives □ difficulty breathing □ swelling of: ______________________________ □ nausea/vomiting □ bleeding □ other: ____
	□ itching □ rash/hives □ difficulty breathing □ swelling of: ______________________________ □ nausea/vomiting □ bleeding □ other: ____
	□ itching □ rash/hives □ difficulty breathing □ swelling of: ______________________________ □ nausea/vomiting □ bleeding □ other: ____
	□ itching □ rash/hives □ difficulty breathing □ swelling of: ______________________________ □ nausea/vomiting □ bleeding □ other: ____
	□ itching □ rash/hives □ difficulty breathing □ swelling of: ______________________________ □ nausea/vomiting □ bleeding □ other: ____
	□ itching □ rash/hives □ difficulty breathing □ swelling of: ______________________________ □ nausea/vomiting □ bleeding □ other: ____

REVIEW Date & initials indicate my review as patient and/or responsible adult.

DATE					
INITIALS					
DATE					
INITIALS					

Patient Sticker

Laurel Surgery & Endoscopy Center LLC

PATIENT SUMMARY – Medications

Date: _____ Patient Name: _____ DOB: _____

If you do not routinely take prescription medications or over-the-counter preparations, initial here → _____

Otherwise, list all prescription & over-the-counter preparations you take, include any currently on hold.

Medication/OTC Preparation	Frequency used	Reason for use

REVIEW Date & initials indicate my review as patient and/or responsible adult.

DATE					
INITIALS					
DATE					
INITIALS					

Patient Sticker

Patient Name:_____ **Birthdate:** _____ Height: _____ ft _____ in Weight: _____ pds

PEDIATRIC PATIENTS TEN YEARS OF AGE AND UNDER

ANESTHESIA HISTORY

Has the child or a blood relative ever had:

Heat stroke requiring hospitalization? □ No □ Yes
Malignant Hyperthermia? □ No □ Yes
Other anesthesia problems? □ No □ Yes
Have you been told that the child has a difficult airway? □ No □ Yes

At which facility? _____

After what procedure? _____

Any procedures since that time? □ No □ Yes

BIRTH

Was the child born prematurely? □ No □ Yes

How many weeks?_____

LUNGS - AIRWAY

Does anyone smoke in the house or car with the child? □ No □ Yes
Does the child snore? □ No □ Yes
Does the child have asthma? □ No □ Yes

HEART – CIRCULATION

Has the child ever seen a cardiologist (heart doctor)? □ No □ Yes

When? _____ Where? _____

Medications changed after this visit? □ No □ Yes

BRAIN

Has the child ever had a seizure? □ No □ Yes

Type? _____

When was the last seizure? _____

Have you ever taken steroids for a long period of time? □ No □ Yes

OTHER

Explain any other medical problems:

_____

_____

_____

_____

_____

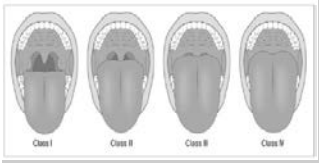
_____ _____
Parent/Responsible Adult Signature Date

-----DO NOT WRITE BELOW THIS LINE-----

For ANESTHESIA use ONLY

CARDIO: _____

RESP: _____



☐ ☐ ☐ ☐ **M**issing **B**roken **L**oose

TESTING: □ **N/A** **HCG** - + FSBS _____ mg/dL

Other Significant: _____

_____

MEDS: □ **N/A** □ **Reviewed** **ALLERGIES:** □ **Reviewed** □ **NKDA**

PROBLEM LIST: □ **N/A**	
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ASA Class: □ **1** □ **2** □ **3** □ **4** **Plan:** □ **MAC** □ **GA** □ **PNB** □ **Neuraxial**

_____
Anesthesia Provider Signature Date

PATIENT STICKER