SOUTHEAST TEXAS SURGICAL ASSOCIATES, P.A.

2900 North Street, Suite 200 • Beaumont, Texas 77702 • (409) 892-0099

Emmett R. Mackan, M.D., Kevin Dean, M.D., S. Scott Kacy, M.D., Iumy Torres, M.D.

Appointment Date: _____ **S.S.#: _____-___-____ D.O.B.:_____**

PLEASE PRINT, SIGN AND DATE THIS CONSENT/ASSIGNMENT IN INK ONLY

Age _____ Gender: M F (circle one)
Referring Physician: _____
Patient Information: **Preferred Pharmacy:_____**
Pharmacy phone #:_____
Name: _____ **E-mail Address: _____**
Last First Middle Maiden

Address: _____ City, State, Zip _____

Home Phone (____) _____ Marital Status _____ Driver's Lic # _____

Employer _____ Phone #:_____ City, State, Zip:_____

Spouse's Name _____ Spouse's Date of Birth _____ Spouse's Social Security # _____

Spouse's Employer _____ City, State, Zip _____

Spouse's Employer Phone _____

PRIMARY INSURANCE

NAME INSURANCE CO #1 _____ POLICY #_____ GROUP # _____

INSURED'S NAME _____ INSURED'S D.O.B. _____

Insurance Address _____ City, State, Zip _____

Insurance Phone _____ Relationship to Patient _____ SS# _____

Employer _____ Employer Address _____

SECONDARY INSURANCE

NAME INSURANCE CO #2 _____ POLICY #_____ GROUP # _____

INSURED'S NAME _____ INSURED'S D.O.B. _____

Insurance Address _____ City, State, Zip _____

Insurance Phone _____ Relationship to Patient _____ SS# _____

Employer _____ Employer Address _____

Emergency Notification

Name_____ Relationship _____

Home Phone _____ Work Phone _____

Assignment of Benefits/Consent for Treatment

Informed consent is hereby given to Southeast Texas Surgical Associates P.A. to perform medical/surgical procedures and to administer such anesthetics/medications which are deemed necessary. I understand that I am financially responsible for all charges for services provided to me, including the unpaid balance after insurance reimbursement. I authorize payment of medical benefits directly to Southeast Texas Surgical Associates, P.A. and authorize the release of medical or other information necessary to process my claims.

Signature _____ Date _____

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GENERAL MEDICAL INFORMATION WORKSHEET

Date: _____ Name: _____

Age: _____ Height _____ Weight _____ Reason for Visit _____

Who referred you to us? _____ _____

Do you smoke? Yes _____ No _____ How many packs each day? _____How long have you smoked? _____

Do you drink alcohol? Yes _____ No _____ If yes, how much? _____

Do you have any drug allergies? Yes _____ No _____ If yes, what are they? _____

_____

Please list any previous surgeries that you have had: _____

_____

_____

Please list any major illnesses that you have had and when: _____

_____

_____

Have you had problems with any of the following?			**If yes, please describe:**
Heart	**Yes _____**	**No _____**	_____
Lungs	**Yes _____**	**No _____**	_____
Kidneys	**Yes _____**	**No _____**	_____
Anemia	**Yes _____**	**No _____**	_____
Abnormal Bleeding	**Yes _____**	**No _____**	_____
Diabetes	**Yes _____**	**No _____**	_____
Hepatitis/Jaundice	**Yes _____**	**No _____**	_____
Other	**Yes _____**	**No _____**	_____

Please list any pertinent family medical history _____

_____

_____

Please list any other medical information: _____

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MEDICATION FLOW SHEET

Date: _____

Patient Name: _____ Age:_____

Medication Allergies: _____

Do you have any seasonal allergies: Yes No Hay Fever

Do you take allergy medications? Yes No Please list below:

Date	Current Medications