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: _______________________
Preferred Pharmacy:________________________
Pharmacy phone #:__________________________
E-mail Address: ___________________________

Patient Information:

Name: ____
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

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BREAST INFORMATION HISTORY

Date: ____________ **Name:** ____ **Age:** _________

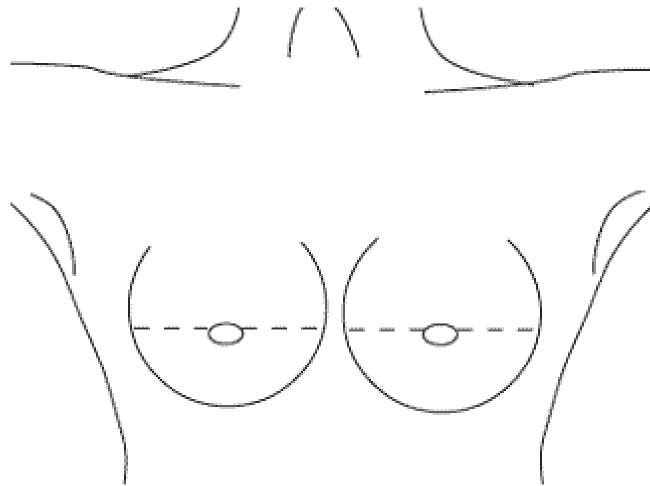
Age at first period: _________________________ **Age at first pregnancy**_____________________________

List any hormones or contraceptive pills ever taken: ____

List any family members with history of breast cancer: ____

Do you examine your breast regularly?	**Yes_____**	**No _____**
Have you ever noticed a lump?	**Yes_____**	**No _____**
How long have the lump/lumps it been present?	______________________________	
Is there tenderness?	**Yes_____**	**No _____**
Can you feel the lump/lumps?	**Yes_____**	**No _____**
Have lumps been found on mammogram/ultrasound?	**Yes_____**	**No _____**
Have you had a previous breast biopsy?	**Yes_____**	**No _____**
Have you had a nipple discharge?	**Yes_____**	**No _____**
Have you had a bloody nipple discharge?	**Yes_____**	**No _____**

Please indicate on the diagram below the location of Lumps or Previous Biopsy:



Is there anything else that you are concerned about or that I should know?______________________

____

____