Dr. Scott L. Sledge, MD, PA
Ashley Book, PA-C

19016 Stone Oak Parkway, Ste 100
San Antonio, TX 78258
Ph(210)494-9600 Fax(210)494-9601

PATIENT INFORMATION (PLEASE PRINT) Today's Date:_____

Last Name:_____ First:_____ M.I.:_____

Address:_____ Apt#:_____ City/State/Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

SS#:_____ Age:_____ DOB:_____ Gender:M / F Marital Status:_____

Employer:_____ Occupation:_____

Employer Address:_____ City/State/Zip_____

Guarantor (if patient is a minor):_____ *Employer*:_____

DOB:_____ *SS#*:_____ *Cell Ph*:_____

Referred by:_____ Primary Care Physician:_____

Pharmacy:_____ Street/City/(Ph#):_____

Emergency Contact:_____ Relationship to Patient: _____ Ph#:_____

INSURANCE INFORMATION

Insured's Name (if different from patient):_____

Insurance Carrier:_____ Insured's DOB:_____ Insured's SS#:_____

Secondary Insurance:_____

IMPORTANT MEDICAL QUESTIONS

Is this a work related injury or related to an automobile accident?_____ If **YES**, please see Receptionist NOW!

What are you being seen for today?_____

Are your symptoms related to an accident/injury? _____

If **YES**, please describe your accident/injury (place it occurred and activity being performed)in as much detail as possible:

Place of occurrence: _____ Activity: _____

_____

I certify the above information is correct. I authorize Scott L. Sledge, MD and Ashley Book, PA-C, of Scott L. Sledge, MD, PA to release or request medical information necessary to process health insurance claims. I authorize payment of my medical insurance benefits to Scott L. Sledge, MD, PA. I understand that I will be responsible for payment at the time services are rendered. This includes any outstanding deductible and/or coinsurance. Our office does not file third party claims. Payment is expected in full. Scott L. Sledge, MD, PA will provide itemize receipts for services provided for reimbursement of third party billing.

*Patient Signature:*_____ *Staff Witness Signature*:_____

If you are referred to Methodist Ambulatory Surgery Center- North Central, we are required, by law, to inform you that Scott L. Sledge, MD, PA, has ownership interest in the facility and may receive remunerations indirectly for services rendered.

Scott L. Sledge, M.D. *Ashley Book, PA-C*

MEDICAL HISTORY

Patient Name:_____ DOB:_____ Age:_____

Medications you are currently taking (including supplements):_____

_____

_____

MEDICATION ALLERGIES:_____

Describe reaction:_____

Do you smoke? Yes / No How many per day?_____

Do you drink alcohol? Yes / No Drinks per week?_____

Do you use illicit drugs? Yes / No

Have you ever had: *(please circle if yes)*

Anemia	Asthma/COPD	Osteoarthritis	Rheumatoid Arthritis
Bursitis/Tendonitis	Cancer	GERD/Ulcers	Diabetes
Epilepsy/Seizures	Gout	HIV	Clotting disorder
Hepatitis	Hypertension	High Cholesterol	Tuberculosis
Kidney disease	Stroke	Venereal disease	Glaucoma
Hypothyroidism	DVT/PE	Depression	MRSA/other infections

Heart trouble →→→→ Cardiologist's Name:_____

Chronic Pain →→→→ Pain Management Doctor:_____

Other:_____

Please list previous SURGERIES/HOSPITALIZATIONS: *(at least the last 5 years)*

Year	Hospital	Physician	Reason/Procedure

Scott L. Sledge, M.D., PA
Attn: HIPAA Officer
19016 Stone Oak Parkway, Ste #100
San Antonio, TX 78258
210-494-9600

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address and phone number listed above.

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

_____

_____

Patient Name: _____
(please print name)

Patient Date of Birth: _____

Signatures:

Patient/Legal Representative: _____ Date: _____

If Legal Representative, relationship to Patient: _____

Witness (optional): _____ Date: _____