McColgan
SURGICAL CLINIC

Referring Physician _____ Today's date_____/_____/_____

Primary Care Physician _____

WHAT PHARMACY DO YOU NORMALLY USE? _____
(We will contact your pharmacy to verify the name and strength of your medications unless otherwise instructed)

Patient Name _____ Date of Birth _____/_____ /_____

Address _____ City _____ State ____ Zip _____

Social Security #_____-_____-_____ Marital Status: Married ____ Single ____ Widowed ____ Other ____

Home Phone _____ Work phone _____ Cell phone _____

Preferred Method of Contact: Call _____ Text _____ Email _____ All Three _____

E-mail address _____

Patient Employer _____ Job Title _____

Employer Address _____

Spouse's Name _____ Spouse's Employer _____

Emergency Contact _____ Relationship _____ Phone No. _____

Insurance (**Primary**) _____

ID#_____ Grp#_____

Policy Holder_____
Your relationship to policy holder_____

Policy Holder Date of Birth _____/_____/_____

Policy Holder SSN _____-_____-_____
(must have Date of Birth and SSN to file a claim)

Insurance (**Secondary**) _____

ID#_____ Grp#_____

Policy Holder _____
Your relationship to policy holder_____

Policy Holder Date of Birth _____/_____/_____

Policy Holder SSN _____-_____-_____
(must have Date of Birth and SSN to file a claim)

ETHNICITY: Hispanic or Latino ____ Non-Hispanic or Latino ____ Multiethnic ____ Refuse to Report ____
RACE: White ____ Black or African American ____ Asian ____ American Indian or Native Alaskan ____
Native Hawaiian or Pacific Islander ____ Other _____ Refuse to Report ____
PREFERRED LANGUAGE: English ____ Spanish ____ Other _____

By signing below, you agree that all information you have provided on the form above is correct to the best of your knowledge
This signature below will also give us consent to call you at any number provided to us above.

Patient Signature/Legal Guardian _____ Today's Date _____/_____/_____

This is a confidential record: Please answer the following questions as completely as you can. If you are uncertain about a question, leave it blank. Information contained here will not be released without your authorization.

Were you referred by a physician? NO ____YES____ Name of physician _____
What symptoms/problems prompted this visit? _____
Other physicians you have seen for this problem: _____
How long have you had your problem? Years _____Months _____Days _____

If you have pain:
Where does it hurt? _____ How severe is it? _____
How long has it hurt? _____ When does it hurt? _____
How does it hurt? _____ What makes it hurt? _____
What makes it hurt less? _____
What other signs or symptoms do you have? _____

MEDICATION ALLERGIES OR SIDE EFFECTS TO MEDICATIONS:

Drug/Medication	Location (skin, local, abdominal, systemic)	Severity (mild, moderate, severe)
_____	_____	_____
_____	_____	_____

MEDICATIONS YOU ARE TAKING: This list must include **ALL** known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medication's name, dosage, frequency and route of administration.

1) _____ 5) _____
2) _____ 6) _____
3) _____ 7) _____
4) _____ 8) _____

ARE YOU CURRENTLY UNDER CONTRACT WITH A PAIN SPECIALIST? No ____ Yes ____
Pain Specialist Name _____ Contact Number _____

ARE YOU PRESENTLY BEING TREATED OR HAVE YOU BEEN TREATED FOR ANY OF THE FOLLOWING:
(Insert Year)

_____ Heart Attack _____ High Blood Pressure _____ Atrial Fibrillation _____ Bleeding Tendency
_____ Anemia _____ Mitral Valve Prolapse _____ Stroke or Paralysis _____ Diabetes
_____ COPD _____ Hepatitis _____ Kidney Disease _____ Thyroid Problems
_____ Cancer (type) _____ _____ Other Illness:_____

PRIOR SURGERIES: (Including outpatient procedures)

	YES	NO	YEAR/PLACE/PHYSICIAN
Tonsillectomy	____	____	_____
Appendectomy	____	____	_____
Hernia Repair	____	____	_____
Gallbladder removal	____	____	_____
Hysterectomy	____	____	_____
Hemorrhoidectomy	____	____	_____
Heart Bypass	____	____	_____
Breast Surgery	____	____	_____
Other	_____		

COLONOSCOPY HISTORY:

If over the age of 50, have you had a colonoscopy within the last 10 years? NO ____ YES ____
Which physician preformed the colonoscopy? _____ What Year? _____
Do you have any family history of colon cancer? NO ____ YES ____ What was their relation to you? _____

FAMILY HISTORY Have any of your blood relatives ever had any of the following diseases?

Heart Disease	_____	Stroke	_____	Arthritis/Gout	_____
Hypertension	_____	Diabetes	_____	Lung Disease	_____
Hepatitis	_____	Cancer (type)	_____	Kidney Disease	_____

OCCUPATIONAL/SOCIAL HISTORY

Present Occupation:_____
If disabled, please explain why_____
Do you smoke or use tobacco products? NO____ YES____ Packs/day_____ Number of Years_____
Have you ever used tobacco products in the past? NO____ YES ____ When did you quit? _____
Alcohol use? Daily _____ Weekly _____ Socially _____ Never _____
Type: Beer _____ Wine _____ Liquor _____

REVIEW OF SYSTEMS: please circle for "Yes" for any that apply to you currently

CONSTITUTIONAL: Fever☐ Weight gain (amount____lbs.)☐ Weight loss (amount____lbs.)☐ Exercise tolerance☐

EYES: Dry eyes☐ Irritation☐ Visual changes☐

EAR, NOSE, THROAT: Difficulty hearing☐ Ear pain☐ Nose bleeds☐ Sinus pain☐ Sore throat☐ Snoring☐

Bleeding gums☐ Dry mouth☐ Teeth problems☐

CARDIOVASCULAR: Chest pain on exertion☐ Arm pain with exertion☐ Shortness of breath when walking☐

Shortness of breath when lying down☐ Palpitations☐ Heart murmur☐ Lightheaded when standing☐

RESPIRATORY: Cough☐ Wheeze☐ Shortness of breath☐ Coughing blood☐ Sleep apnea☐

GASTROINTESTINAL: Abdominal pain☐ Vomiting☐ Change in appetite☐ Black or tarry stools☐ Diarrhea☐

Reflux/heartburn☐ Vomiting blood☐ GERD☐ Nausea☐

GENITOURINARY: Incontinence☐ Difficulty urinating☐ Blood in urine☐ Increased urinary frequency☐

Incomplete emptying☐

MUSCULOSKELETAL: Muscle aches☐ Weakness☐ Joint pain☐ Back pain☐ Swelling in extremities☐

INTEGUMENTARY: Abnormal mole☐ Jaundice☐ Rash/itching☐ Dry skin☐ Growths/lesions☐ Laceration☐

NEUROLOGIC: Loss of consciousness☐ Weakness☐ Numbness☐ Seizures☐ Dizziness☐

Headaches☐ Restless legs☐

PSYCHIATRIC: Depression☐ Sleep changes☐ Restless sleep☐ Alcohol abuse☐

ENDOCRINE: Fatigue☐ Increased thirst☐ Hair loss☐ Increased hair growth☐ Cold intolerance☐

HEMATOLOGIC/LYMPHATIC: Swollen lymph nodes☐ Easy bruising☐ Excessive bleeding☐

ALLERGIC/IMMUNOLOGIC: Runny nose☐ Sinus pressure☐ Itching☐ Hives☐ Frequent sneezing☐

BREAST: Perform monthly self-breast exams☐ Yearly mammograms☐

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Specific Authorization for Family Member/Friend

I,_____direct my health care and medical services providers and payers to disclose and release my protected health information to:

Name	Relationship	Contact Information
_____	_____	_____
_____	_____	_____
_____	_____	_____

This authorization shall be effective until (check one):

_____ All past, present, and future periods, OR
_____ Date or Event: _____

unless I revoke it (NOTE: You may revoke this authorization in writing at any time by notifying your health care provider, preferably in writing.)

_____ _____
Name of Individual Giving this Authorization Date of Birth

_____ _____
Signature of Individual Giving this Authorization Date

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Notice of Recorded Physician/Patient Encounter

Our office utilizes a HIPAA compliant artificial intelligent (AI) medical scribe technology to assist the physician with patient encounters and documentation. By making use of this technology, the physician is able to focus more on patient care.

I, (the "Patient") give my permission, as indicated below, to be audio recorded during my medical visits.

I consent to using the AI medical scribe services to use these recordings and personal information collected during the recordings, including health information, for the following services, which includes but is not limited to, medical documentation, medical transcription, quality assurance, training, software improvement, and voice analytics purposes.

I understand that any or all of the information provided by me or my care team during the recordings may be used and disclosed for the above- indicated purposes, including personal and health information about myself.

I, _____, **consent** to the use of the AI medical scribe during my medical encounters/appointments.

Patient Signature: _____ **Date** _____/_____/_____

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Important Notice

Notice of Charge for Completion of Forms

Beginning February 1, 2001, we will require payment for the completion of forms you ask us to complete on your behalf. We receive many requests for completion of these forms. This requires extra work, time, and financial resources in excess of what is normally needed to complete the medical record.

We will make every effort to complete these forms within 5 business days, however, we cannot make any assurance of completion within your time frame(s).

Payment is required prior to completion of the form(s).

A charge of $10 per form applies to completion of the following forms:

- Disability and Family Leave Medical Act
- Personal disability insurance forms
- Loan payment forms
- Credit insurance forms
- Other insurance policy forms that make loan payments in the event of disability
- Unemployment insurance forms

A charge of $20 applies to the completion of the above forms if completion is required in 24 hours or less.

There will not be a charge to complete regular insurance claim forms for payment of services to our clinic for visits and/or surgical procedures by your health insurance company.

The following forms will be completed at no charge to the patient:

- Application for public assistance forms
- Worker's Compensation forms
- Social Security Administration

Instructions:

Payment is required prior to completion of the form(s).

- We are not obligated to complete these forms but do so as a courtesy to you. We reserve the right to refuse to complete any forms you present to us for completion.
- Please submit your request for completion of forms well in advance of when they are needed. We will attempt to complete the forms as quickly as possible; however, in order to properly address them we need adequate time to review your records.
- Please make sure that all of your information is completed on the form before you give it to us.
- Do not complete the section(s) of the form that are required to be completed by our office.
- Forms which require comprehensive review of patient records, analysis, and a detailed response may be charged a higher fee. We will inform you of these charges at the time the services are requested.

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SURGICAL CLINIC

AUTHORIZATION OF TREATMENT: I GIVE AUTHORIZATION TO DR. MCCOLGAN FOR MEDICAL TREATMENT.

AUTHORIZATION FOR RELEASE OF INFORMATION: I AUTHORIZE DR. MCCOLGAN TO SUBMIT ANY INFORMATION NEEDED BY MY INSURANCE COMPANY OR COMPANIES TO FACILITATE PAYMENT OF CLAIMS.

I AUTHORIZE DR. MCCOLGAN TO RELEASE MY INFORMATION TO THE HOSPTIAL AND/OR SURGERY CENTER FOR SCHEDULING SURGERY OR TESTS, OR A REFERRING PHYSICIAN FOR SCHEDULING AN APPOINTMENT.

CONFIDENTIALITY: I UNDERSTAND DR. MCCOLGAN USES THIRD PARTIES OR MEDICAL TRANSCRIPTION, ACCOUNTING AND CLEANING SERVICES. THESE COMPANIES HAVE AN AGREEMENT TO KEEP ALL PATIENT INFORMATION CONFIDENTIAL. I UNDERSTAND THE OFFICE OF DR. MCCOLGAN MAY CALL MY HOME AND/OR WORK PHONE NUMBER TO CONFIRM OR RESCHEDULE APPOINMENTS AND/OR TO DISCUSS MY BILL OR INSURANCE ISSUES WITH ME. THEY MAY LEAVE A MESSAGE AT MY HOME OR WORK UNLESS OTHERWISE INSTRUCTED BY ME. I UNDERSTAND THAT I HAVE THE RIGHT TO ASK THAT SPECIFIC PERSONS NOT BE PRIVY TO ANYTHING REGARDING MY PHI. THIS REQUEST MUST BE ISSUED TO DR. MCCOLGAN'S OFFICE IN WRITING.

I WILL INFORM DR. MCCOLGAN'S OFFICE IF MEMBERS OF MY IMMEDIATE FAMILY MAY NOT BE INFORMED OF MY MEDICAL CONDITION.

ASSIGNMENT OF BENEFITS: I AUTHORIZE MY INSURANCE COMPANY TO MAKE PAYMENT DIRECTLY TO DR. MCCOLGAN ON MY BEHALF. I ALSO REALIZE I AM RESPONSIBLE TO PAY ANY DEDUCTIBLE AND COPAYMENT AND/OR COINSURANCE AMOUNTS STATED BY MY POLICY. I HAVE READ AND UNDERSTAND THE BILLING AND COLLECTIONS POLICY FOR WILLIAM L. MCCOLGAN, III, M.D., P.A. AND AGREE TO ITS ENFORCEMENT. IF PAYMENT IS NOT RENDERED IN A TIMELY MANNER (UNLESS OTHER ARRANGEMENTS ARE MADE) AND MY ACCOUNT IS SENT TO COLLECTIONS, I WILL BE RESPONSIBLE FOR ALL ATTORNEY FEES, COURT FEES, AND/OR COLLECTION FEES, NOT TO EXCEED 35%.

I UNDERSTAND THAT I WILL BE CHARGED ADDITIONAL FEES FOR COMPLETION OF FORMS OTHER THAN MY NORMAL HEALTH INSURANCE CLAIM FORM.

EFECTIVE 1/1/2026, IF I AM UNABLE TO KEEP MY UPCOMING APPOINTMENT(S), I UNDERSTAND THAT I MUST NOTIFY THE OFFICE AT LEAST 24 HOURS IN ADVANCE OR A FEE OF $50.00 WILL BE CHARGED TO MY ACCOUNT.

_____ _____/_____/_____

PATIENT OR GUARANTOR SIGNATURE DATE