Lubbock Surgery Center

Please print and fill out the attached Pre-Registration Forms, ***for adult patients***, and bring them with you on the day of your visit. If you have any questions or need assistance filling out these forms, please do not hesitate to contact me via email or phone.

Thank you,

The Staff at Lubbock Surgery Center

Lubbock Surgery Center
T: 806.796.3005
E: reception@lubbocksc.com

LUBBOCK
SURGERY
CENTER

PATIENT INFORMATION

Patient Name (Last, First, Middle) Social Security Number

Date of Birth Age Sex Marital Status

Race: ☐American Indian ☐ Asian ☐Black/African American ☐Other Pacific Islander ☐Caucasian ☐Hispanic

Ethnicity: ☐Hispanic/ Latino ☐Non-Hispanic or Latino

Mailing Address **(City, State and Zip)** Phone Number

Residing Address (If Different) Cell Phone Number

Email Address

Employer

Employer’s Address (City, State and Zip) Employer’s Phone Number

Guarantor/Responsible Party Social Security Number Relationship

Guarantor/Responsible Party’s Mailing Address Phone Number

Guarantor/Responsible Party’s Employer

Guarantor/Responsible Party’s Employers Address (City, State and Zip) Employer’s Phone Number

Person to Contact in an Emergency (Who Does Not Live with You)

Address (City, State and Zip) Phone Number

INSURANCE INFORMATION

Primary Insurance Carrier Policy Owner/s Name Social Security Number Date of Birth

Insurance ID Number Group Number Group Name

Mailing Address (City, State and Zip)

Secondary Insurance Carrier Policy Owner’s Name Social Security Number Date of Birth

Insurance ID Number Group Number Social Security Number Date of Birth

Mailing Address (City, State and Zip)

IS THIS A WORK-RELATED INJURY? ☐YES ☐NO If “YES”, Please Provide the Information Below.

Date of Injury Date Reported to Employer Supervisors Name

Employer Employer Address Telephone Number

Employer’s Workers Compensation Insurance Company File/Claim Number

LSC USE ONLY: Date of Surgery__________ Physician ____________Med Record #________Date of Pre-Registration ____________

Medication Reconciliation Form

Source of Information:

☐ Unable to Contact ☐ Patient Questionnaire ☐ Patient/Family ________________________ ☐ Pharmacy ___________________

☐ **No Known Allergies**

Allergies

Allergy:	**Reaction:**	**Allergy:**	**Reaction:**	**Allergy:**	**Reaction:**

☐ Allergies continued on attached ☐ Medications continued on attached

Current Medication

☐ **Patient is not currently taking any medications or supplements**

Medication	**Dose**	**Frequency**	**Date of Last Dose**	**Resume Medication**
				☐today ☐other
				☐today ☐other
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The current medication and allergy list are complete and accurate ____

Patient Signature

☐**Patient has not been prescribed any new medications today**

____ **Nurse Signature**

_______________________________________**Physician Signature**

Page _______ of _______

Permission for Disclosure to Family, Friends, and/or Caregivers

To Patient:

I understand patient health information is protected and confidential. With this understanding, I hereby grant the **Lubbock Surgery Center** staff permission to discuss my health-related matters with family, friends, caregivers or other designated persons, listed below.

Relevant health information may be shared with the following family members, other relatives, close personal friends, or other persons identified. Please mark applicable line and insert name of person or persons applicable.

____	____
Name	Relationship
____	____
Name	Relationship
____	____
Name	Relationship
____	____
Name	Relationship
____	____
Name	Relationship
____	____
Name	Relationship

Disclosure UPDATED by patient:

Date and initial of patient:	__________________	__________________	_________________
	__________________	__________________	_________________
	__________________	__________________	_________________
	__________________	__________________	_________________

Patient Name: ____ **Date:** ________________

Patient Signature: ____

Pre-Anesthetic Questionnaire

Patient Name: ______________________________

Daytime phone # ______________________________ **Procedure**______________________________

DRUG & FOOD ALLERGIES: | | None List (explain reaction)**:** ______________________________

____

____

Latex allergy/sensitivity to tape/band-aids? **Circle: Yes No**

Ht _______ **Wt/BMI** ______________**(pounds)**_______**(kg)**

Prior surgeries: ______________________________

____

____

____

Tobacco use? Yes No _______packs/day x _______years

Alcohol use? Yes No # drinks per day/week: __________

Caffeine use? Yes No # drinks per day/week: __________

Have pain? Yes No Where: __________1-2-3-4-5-6-7-8-9-10

****ANESTHESIA PROBLEMS** for you or any blood relative **(i.e., delayed awakening, MALIGNANT HYPERTHERMIA, unexplained fever, difficult intubation, vomiting)? Yes No If yes, explain:**______________________________

____

Which of the following do you have or have you had in the past? Please circle Yes or No to each question.

CARDIAC HISTORY

- **Y N Chest pain**
- **Y N Heart attack**
- **Y N Heart failure**
- **Y N Mitral valve prolapse**
- **Y N Rheumatic fever**
- **Y N Heart murmur**
- **Y N Irregular heartbeats**
- **Y N Aneurysms**
- **Y N Heart catheterization or stents**
- **Y N Heart surgery (e.g. bypass)**
- **Y N Pacemaker/Defibrillator**
  - Date last checked**:** _______
- **Y N Artificial heart valve**
- **Y N High blood pressure**
- **Y N Cholesterol**

RESPIRATORY HISTORY

- **Y N Asthma**
- **Y N Emphysema or COPD**
- **Y N Chronic cough**
- **Y N Shortness of breath**
- **Y N Sleep APNEA and/or CPAP**

OTHER MEDICAL HISTORY

- **Y N Blood Clots in legs or lungs**
- **Y N Tuberculosis**
- **Y N Diabetes:**
  - **If yes, circle below:**
  - Insulin Pills Diet
- **Y N Hypoglycemia**
- **Y N Kidney disease**
  - If yes, do you have a dialysis shunt or on dialysis? _______________
  - ______________________________

- **Y N Ulcers**
- **Y N Weight loss**
- **Y N Thyroid disease**
- **Y N Liver disease**
- **Y N Hepatitis**
  - Circle type if yes: A B C
- **Y N Lupus**
- **Y N Anemia**
- **Y N Bruise or bleed easily**
- **Y N Sickle cell disease**
- **Y N Strokes**
  - Y N weakness?
- **Y N TIA (mini-stroke)**
- **Y N Parkinson's disease**
- **Y N Seizures or epilepsy**
  - Date of last seizure:
  - ____________________
- **Y N Migraines**
- **Y N Memory loss**
  - If yes, do you sign your papers? Y N
- **Y N Psychiatric disorders**
- **Y N Depression**
- **Y N Glaucoma**
- **Y N Artificial joints**
- **Y N Artificial limbs**
- **Y N Amputee**
- **Y N Back pain**
- **Y N Neck pain**
- **Y N Herniated discs**
- **Y N Cancer**
  - Type: _______________
  - Chemotherapy
  - Radiation therapy

Birth defects: _____________

____

DO YOU:

- **Y N Have anything contagious** (fever, cough rash, open sores)
- **Y N Have MRSA, AIDS or HIV**
- **Y N Have night sweats**
- **Y N Use recreational drugs**
- **Y N Get preventative antibiotics before procedures**
- **Y N Have you had any recent respiratory infections, other type of infections or hospitalization**
  - Describe and list date(s) ______
  - ______________________________
- **Y N Wear Oxygen**
  - Type: ____________________
- **Y N Wear contact lenses**
- **Y N Wear glasses**
- **Y N Wear hearing aids**
- **Y N Have body piercing** (besides ears) If yes, where?
  - ______________________________
- **Y N Have dentures, partials, loose teeth or periodontal disease**
- **Y N Use cane, walker or wheelchair**
- **Y N Are you prone to falling**
- **Y N Have an ostomy**
  - ______________________________
- **Y N Need a translator day of surgery**
  - If yes, what language:
  - ______________________________

- **Y N Take blood thinners or anti-Inflammatories** (Plavix, Coumadin, Pradaxa, Effient, Aspirin, Motrin, Advil, Aleve, Mobic, Naprosyn, Celebrex, Aggrenox, etc.)

Did you stop this medication? Y N

Date last taken: ______________

WOMEN ONLY:

- **Y N Are you pregnant now**
- **Y N Are you breastfeeding now**
- **Y N Take hormones or Tamoxifen**
- **Y N Ever had a tubal or hysterectomy**
  - **Last menstrual cycle**
  - Date____________________

____________________ __________

Nurse Signature Date

____

____

____

____

____

____

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____

____

Please list the name(s) of your current physician(s) (i.e. primary care physician, cardiologist, pediatrician, orthopedist)**:**

Physician name	**Specialty**	**Date of visit**

Emergency contact (name/phone number): ______________________________ **Responsible Adult:** ______________________________

I certify that my health history was reviewed and updated by me on: (sign once per date of service)

Today's Date	**Patient Signature**	**Witness**
Today's Date	**Patient Signature**	**Witness**
Today's Date	**Patient Signature**	**Witness**