

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



PATIENT INFORMATION

Patient Name (Last, First, Middle)		Social Security Number	
Date of Birth	Age	Sex	Marital Status
Race: <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic			
Ethnicity: <input type="checkbox"/> Hispanic/ Latino <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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-1119/08012017	LSC USE ONLY: Date of Surgery _____	Physician _____	Med Record # _____ Date of Pre-Registration _____

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.

<p>CARDIAC HISTORY</p> <p>Y N Chest pain</p> <p>Y N Heart attack</p> <p>Y N Heart failure</p> <p>Y N Mitral valve prolapse</p> <p>Y N Rheumatic fever</p> <p>Y N Heart murmur</p> <p>Y N Irregular heartbeats</p> <p>Y N Aneurysms</p> <p>Y N Heart catheterization or stents</p> <p>Y N Heart surgery (e.g. bypass)</p> <p>Y N Pacemaker/Defibrillator Date last checked: _____</p> <p>Y N Artificial heart valve</p> <p>Y N High blood pressure</p> <p>Y N Cholesterol</p> <p>RESPIRATORY HISTORY</p> <p>Y N Asthma</p> <p>Y N Emphysema or COPD</p> <p>Y N Chronic cough</p> <p>Y N Shortness of breath</p> <p>Y N Sleep APNEA and/or CPAP</p> <p>OTHER MEDICAL HISTORY</p> <p>Y N Blood Clots in legs or lungs</p> <p>Y N Tuberculosis</p> <p>Y N Diabetes: If yes, circle below: Insulin Pills Diet</p> <p>Y N Hypoglycemia</p> <p>Y N Kidney disease If yes, do you have a dialysis shunt or on dialysis? _____</p>	<p>Y N Ulcers</p> <p>Y N Weight loss</p> <p>Y N Thyroid disease</p> <p>Y N Liver disease</p> <p>Y N Hepatitis Circle type if yes: A B C</p> <p>Y N Lupus</p> <p>Y N Anemia</p> <p>Y N Bruise or bleed easily</p> <p>Y N Sickle cell disease</p> <p>Y N Strokes Y N weakness?</p> <p>Y N TIA (mini-stroke)</p> <p>Y N Parkinson's disease</p> <p>Y N Seizures or epilepsy Date of last seizure: _____</p> <p>Y N Migraines</p> <p>Y N Memory loss If yes, do you sign your papers? Y N</p> <p>Y N Psychiatric disorders</p> <p>Y N Depression</p> <p>Y N Glaucoma</p> <p>Y N Artificial joints</p> <p>Y N Artificial limbs</p> <p>Y N Amputee</p> <p>Y N Back pain</p> <p>Y N Neck pain</p> <p>Y N Herniated discs</p> <p>Y N Cancer Type: _____ Chemotherapy Radiation therapy</p> <p>Birth defects: _____</p>	<p>DO YOU:</p> <p>Y N Have anything contagious (fever, cough rash, open sores)</p> <p>Y N Have MRSA, AIDS or HIV</p> <p>Y N Have night sweats</p> <p>Y N Use recreational drugs</p> <p>Y N Get preventative antibiotics before procedures</p> <p>Y N Have you had any recent respiratory infections, other type of infections or hospitalization Describe and list date(s) _____</p> <p>Y N Wear Oxygen Type: _____</p> <p>Y N Wear contact lenses</p> <p>Y N Wear glasses</p> <p>Y N Wear hearing aids</p> <p>Y N Have body piercing (besides ears) If yes, where? _____</p> <p>Y N Have dentures, partials, loose teeth or periodontal disease</p> <p>Y N Use cane, walker or wheelchair</p> <p>Y N Are you prone to falling</p> <p>Y N Have an ostomy</p> <p>Y N Need a translator day of surgery If yes, what language: _____</p>	<p>Y N Take blood thinners or anti-Inflammatories (Plavix, Coumadin, Pradaxa, Effient, Aspirin, Motrin, Advil, Aleve, Mobic, Naprosyn, Celebrex, Aggrenox, etc.)</p> <p>Did you stop this medication? Y N Date last taken: _____</p> <p>WOMEN ONLY:</p> <p>Y N Are you pregnant now</p> <p>Y N Are you breastfeeding now</p> <p>Y N Take hormones or Tamoxifen</p> <p>Y N Ever had a tubal or hysterectomy Last menstrual cycle Date _____</p> <p>_____ Nurse Signature Date</p> <p>_____ _____ _____ _____ _____ _____ _____</p>
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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
_____	_____	_____