Lubbock Surgery Center

Please print and fill out the attached Pre-Registration Forms, ***for pediatric 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: □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-1119/08012017 **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
				□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: ____________________________________

LSC-P005

PRE ANESTHETIC ASSESSMENT- PEDIATRIC

Patient Name:________________________

Responsible Party________________________ Daytime Phone#__________________________Procedure__________________________

Wt__________**(lbs)**____________**(kg)** My nickname is_________________________ **NPO**: Time:__________ Verbalized Understanding ☐

I am **allergic** to (**drug & food**)____**Latex allergy /Sensitivity** to tape/band-aids**?** ☐ Yes ☐ No

Medications / Supplement(s) List: Med/Rec Form Completed ☐ **Yes** ☐ **No** Hospitalizations____

Surgeries I have had ____Are immunizations up to date? ☐ Yes ☐ No

Anesthesia Problems: *Patient~*____________________________________ *Relative~* ____

(i.,e. unexplained fever, MALIGNANT HYPERTHERMIA, nausea/vomiting)

I have pain ☐ **Yes** ☐ **No** Where? ____ If yes, is it Mild (0-3) Moderate (4-7) or Severe (8-10)

Patient lives with: ____ Last name if different: ______________________________________

Who will be with patient the day of surgery________________________________ ****Power of Attorney needed if child will be with someone other than custodial parent**** Other info the doctor should know: ____

PLEASE READ CAREFULLY AND CIRCLE ALL THAT APPLY TO YOUR CHILD

CARDIOVASCULAR	RESPIRATORY	NEUROMUSCULAR		AIRWAY
NO PROBLEM	**NO PROBLEM**	**NO PROBLEM**		**NO PROBLEM**
ANEMIA	ASTHMA	ADD / ADHD	SPINAL DEFORMITIES	LOOSE TEETH:
BLEEDING TENDENCIES	ALLERGIES	CEREBRAL PALSY	MUSCULAR DYSTROPHY	_________________
MURMUR	NASAL CONGESTION	SEIZURE: FREQUENCY:___________________		MISSING TEETH:
RHEUMATIC FEVER	RECENT COLD/INFECTIONS	MENTAL OR PHYSICAL DISABILITY OR DELAY		_________________
OTHER:	OTHER:	***FAMILY HISTORY OF ABOVE*** ☐ YES ☐ NO		BRACES
		OTHER:		OTHER:

ENDOCRINE	GI / GU	BIRTH	MISCELLANEOUS
NO PROBLEM	**NO PROBLEM**	NORMAL FULL TERM	RASHES
DIABETES: CONTROLLED BY:	KIDNEY DISEASE	PREMATURE:	ANYTHING CONTAGIOUS
DIET MEDICATION INSULIN	URINARY INFECTION	Birth Wt.___________________	HEARING AIDS
RHEUMATOID ARTHRITIS	STOMACH PROBLEMS		GLASSES/CONTACTS
OTHER:	OTHER:	GROWTH/DEVELOPMENT FOR AGE:	Last Menstrual Cycle: ____________
		Within normal limits ☐ YES ☐ NO	OTHER:

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

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

____
____
____

Notes: ____
____
____
____
____
____
____

____
Signature **Date**
☐ Parent ☐ Guardian ☐ Other

____
Nurse Signature **Date**

I certify that my health history was reviewed and updated by me on:

____
Today's Date **Patient/Parent/Guardian Signature** **Witness**

____
Today's Date **Patient/Parent/Guardian Signature** **Witness**

____
Today's Date **Patient/Parent/Guardian Signature** **Witness**

____
Today's Date **Patient/Parent/Guardian Signature** **Witness**