ROGER LAND, M.D., P. C.
GENERAL SURGERY

Chart #
PATIENT INFORMATION DATE: _____

Patient Name: _____ S.S. #_____ Age_____

Address: _____ City _____ State _____ Zip_____

Home Phone: _____ Work Phone: _____ Birthday: _____

Cell Phone:_____

□Male □ Female Please check appropriate box: □Married □ Single □ Widowed

Employer: _____

Business address: _____

GUARANTOR INFORMATION- If Under Age 18 or Spouse Insurance

Name: _____ Address: _____

Date of Birth: _____ S.S. # _____

Employer: _____ Address: _____

EMERGENCY CONTACT (other than spouse)

Name: _____ Address: _____

Phone: _____ Relationship: _____

RELEASE OF MEDICAL / OTHER INFORMATION

- I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such care to third party payors and/or other health practitioners.
- I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.
- I understand that my insurance carrier may pay less than the actual amount of services. I agree to be responsible for payment of all services rendered on my behalf or my dependents within the confines of the insurance contracts.
- I agree to pay any interest, collection or attorney fees owed in addition to court costs if charges are not paid according to established policy and legal action is necessary to affect collection.
- I have read all the above and the information given is true.

SIGNATURE / PARENT IF MINOR _____ DATE _____

ROGER L. LAND, M.D., P.C.
INITIAL CLINICAL HISTORY AND PHYSICAL

Date: _____

Patient Information Chart #_____

Name: _____ Age: _____ Date of Birth:_____/_____/_____

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ Multi-Racial ☐ Other _____

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed # Children _____

Primary Care Physician: _____ Referring Physician: _____

Reason for Visit: _____

Past Medical History
(Please **CIRCLE** all conditions that you have or have had.)

None	Anxiety	High Cholesterol	Allergy: Food
Heart Disease (Dr._____)	Bleeding Difficulties	Seizure	Allergy: Seasonal
High Blood Pressure	Hepatitis A B or C	Loss of Consciousness	TB
Stroke/TIA	HIV	Arthritis (Type) _____	Hypothyroid
Obstructive Sleep Apnea	Diabetes-Diet Controlled	Asthma	Hyperthyroid
Coronary Artery Disease	Diabetes-Oral Meds	Emphysema	Pain Management
Depression	Diabetes-On Insulin	Osteoporosis	

Cancer: Type/Treatment: _____

History of Breast Cancer: _____

Other (Specify): _____

Past Surgical History
(Type of Surgery & Year)

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

Prescription Medications

Medication	Dose/Number per Day	Medication	Dose/Number per Day
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Herbs – **Yes or No**

Type_____

ROGER L. LAND, M.D., P.C.

Patient Name: _____ DOB_____ Chart # _____

Drug Allergies /Type of Reaction

No known drug allergies
Latex
Tape

1. _____
2. _____
3. _____
4. _____

Social History
(Please check the appropriate listings)

Tobacco Use	Alcohol Use	Drug Use	Exercise	Caffeine Use
Never	☐ None	☐ None	☐ None	☐ None
Quit/When? _____	Socially	☐ Marijuana	☐ 1-2x/week	☐ Occasional
Cigarettes/Pack per Day? _____	Daily	☐ Amphetamines	☐ 3-4x/week	☐ Daily
Pipe	☐ Heavy	☐ Other _____	5-7x/week	
Cigars				
Chewing Tobacco	Have you ever been treated for alcoholism?	Have you ever been treated for drug use?	Type: _____	How much? _____
How many years? _____	Yes ☐ No	☐ Yes ☐ No	_____	_____
	If yes, when? _____	If yes, when? _____	_____	_____

Any religious beliefs that would affect your medical care? _____

Education
(Please check highest level)

Grade School ☐ **High School** ☐ **College** ☐ **Post Graduate**

Occupational History

Employer: _____ Job Title: _____

Have you altered your job as a result of the problem you brought here today? ☐Yes ☐No

If yes, please explain: _____

If you're currently off work as a result of the problem, how long have you been off? _

Family History

Father	Living Deceased	Age: _____	Medical History or Cause of Death	High Blood Pressure ☐ Diabetes ☐ Cholesterol Cancer: Type_____☐ Other _____
Mother	Living Deceased	Age: _____	Medical History or Cause of Death	High Blood Pressure ☐ Diabetes ☐ Cholesterol Cancer: Type_____☐ Other _____
Brothers	# Living _____ # Deceased _____	Age: _____	Medical History or Cause of Death	High Blood Pressure ☐ Diabetes ☐ Cholesterol Cancer: Type_____☐ Other _____
Sisters	# Living _____ # Deceased _____	Age: _____	Medical History or Cause of Death	High Blood Pressure ☐ Diabetes ☐ Cholesterol Cancer: Type_____☐ Other _____

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For Females:

Are you pregnant? _____ Are you breast feeding? _____ # of Pregnancies/Deliveries: _____ Type of Birth Control: _____

Date of first menstrual period: _____ Date of last menstrual period: _____

Last Mammogram: _____ Last Pap: _____ Last Bone Density Scan: _____

For Males:

Do you experience impotency? _____ Erectile Problems: _____

Immunizations:

Flu Date: _____ Pneumonia Date: _____ Tetanus Date: _____

Other:

Screenings: _____ Colonoscopy Date: _____

T:_____

P:_____

B/P_____

WT:_____

HT:_____

PAIN SEVERITY:_____

MD_____

DATE_____

ROGER L. LAND, M.D., P.C.

NAME:_____ **DATE:**_____

S.S.#_____ **CHART#:**_____

In an effort to protect each person's privacy, Roger L. Land, M.D., P.C., and his staff are **NOT** allowed to give information on any patient, whether by phone or in person without written permission from the patient. We will **NOT** allow persons other than yourself to pick up medical records, test results, disability forms, prescriptions, etc., **unless prior written permission is obtained from you the patient.**

PLEASE SPECIFY THE PEOPLE YOU ARE GIVING WRITTEN PERMISSION FOR

* _____

* _____

* _____

* _____

* _____

1.___ YES ___ NO Do we have your permission to call your home to discuss appointments of test and/or procedures and results of test/procedures?

2.___YES ___ NO Do we have your permission to call your workplace to discuss appointments, scheduling of test/procedures and test results?

3.___YES ___NO May we leave a message at your home to persons other than yourself, or on an answering machine to please call our office?

4.___YES___NO Do we have your permission to call your cell phone number to discuss appointments, scheduling of test and/or procedures and results of test/procedures?

SIGNATURE:_____

Acknowledgement of Receipt of Notice of Privacy Practices

(To be filed in patients medical records)

I have been presented with a copy of the Notice of Privacy Practices detailing how my health information may be used and disclosed as permitted under federal and state law and outlining my rights regarding my health information.

Signed_____ Date:_____

Relationship (If not signed by patient):_____

I wish to place the following restrictions on disclosure of my health information:

Internal Use Only

If patient/patient's representative refuses to sign acknowledgment, please document date and time notice was presented to patient and sign below.

Presented on (date and time):_____

By (name and title):_____