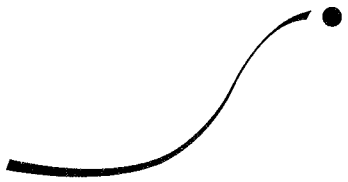

advanced surgical associates

Tiong Oen Pouw, M.D., F.A.C.S.
Carlos A. Vieira, M.D., F.A.C.S.
George M. Wairiuko, M.D., F.A.C.S.

2451 Intelliplex Dr., Suite 280
Shelbyville, Indiana 46176
Phone: 317-392-0222
Fax: 317-392-0722

To whom it may concern;

Thank you for choosing Advanced Surgical Associates for your medical needs. To expedite the registration process, we are forwarding to you the patient documentation required for your medical file. Please have these forms completed prior to your arrival.

Please bring the following items to your appointment: insurance card(s), photo ID, and a list of all current medications. Any office visit co-pays are due and payable at the time of your arrival. If you are unable to provide your co-pay upon arrival, you may be asked to reschedule your appointment. Please provide at least 24 hours advanced notice of any appointment cancellations or changes. Failure to keep appointment without notifying us or giving our office 24 hours advanced notice of any cancellations or changes may result in a fee of $25 due before any new appointments can be made. It is recommended that you arrive a few minutes early to your appointment. Patients arriving more that 15 minutes past their scheduled appointment time may be asked to reschedule.

If you have any questions, please feel free to contact our office.

Thank you,

Advanced Surgical Associates, LLC

Name: _____

Pharmacy & Location: _____

Medication List - Including any over the counter meds, vitamins, etc.

Medication Name:	Dose and Frequency:	Notes:

Medication Allergies: If there are No known medication allergies please write "None"

	Notes:

Advanced Surgical Associates, LLC
2451 Intelliplex Drive, Suite 280 Phone 317.392.0222
Shelbyville, Indiana 46176 Fax 317.392.0722

1. PATIENT INFORMATION – page 1 of 1

Name (Last, First, MI):			Social Security #:	
Street Address:			Race:	Ethnicity:
City:			State:	ZIP:
Home Phone:	Cell Phone:	Birthdate:	Male/Female:	Marital Status:
Emergency Contact (not living in your home):	Emergency Contact Phone:		Your Relationship to Emergency Contact:	
Employer/Company Name:			Employer's Phone:	
Family Doctor	Family Doctor Phone number		**Email:**	

2. GUARANTOR'S INFORMATION (Person responsible for the account.) ☐ Check here if address information below is the same as above.

Guarantor Name (Last, First, MI):			Social Security #:	
Street Address:			P.O. Box:	Apartment #:
City:			State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Birthdate:	
Guarantor's Employer:			Guarantor's Employer's Phone:	
Guarantor's Employer's Street Address:	City:		State:	ZIP:
Guarantor's Relationship to Patient:				

3. INSURANCE INFORMATION

☐ Yes ☐ No Do you have **Medicare Part B?**	**Medicare Number:**
☐ Yes ☐ No If you have Medicare Part B, do you also have Medigap or other supplemental coverage?	**If yes, Medigap or other supplemental coverage information may be completed in the secondary insurance section below.**
☐ Yes ☐ No Do you have **Medicaid?**	**Medicaid Number:**
☐ Yes ☐ No If pregnant, do you have maternity insurance coverage?	
Primary Insurance Company:	**Secondary Insurance Company:**
Policy Owner's Name (Last, First, MI):	Policy Owner's Name (Last, First, MI):
Policy Owner's Social Security #:	Policy Owner's Social Security #:
Policy Owner's Birthdate:	Policy Owner's Birthdate:
Insurance Company Street Address:	Insurance Company Street Address:
City/State: ZIP:	City/State: ZIP:
Policy Owner's Relationship to Patient:	Policy Owner's Relationship to Patient:
Policy/Plan Number:	Policy/Plan Number:
Account/Group Number:	Account/Group Number:
Employer/School:	Employer/School:
Office Co-Pay:	Office Co-Pay:

4. IF PATIENT IS A MINOR OR STUDENT, PLEASE COMPLETE THE FOLLOWING INFORMATION.

Father's Name (Last, First, MI):	**Mother's** Name (Last, First, MI):
Street Address:	Street Address:
City/State/ZIP:	City/State/ZIP:
Home Phone: Work Phone:	Home Phone: Work Phone:

Advanced Surgical Associates, LLC
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Shelbyville, Indiana 46176 Fax 317.392.0722

AUTHORIZATION to DISCLOSE HEALTH INFORMATION

I, _____, give my consent for Advanced Surgical Associates, LLC, to release medical and billing information to the **following person(s):**

Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:

I also understand that it is my responsibility to notify Advanced Surgical Associates, LLC, of any changes to this authorization. **This authorization is valid indefinitely unless we receive written notification of requested changes.**

I give Advanced Surgical Associates, LLC, permission to leave messages regarding my test results, appointment reminders, and any other information pertaining to my medical record on/with:

☐ Voice Mail ☐ Answering Machine ☐ Family Member ☐ Other _____

Signature of Patient, Parent, or Legal Guardian	Date
Printed Name of Patient, Parent, or Legal Guardian	Date
Signature of Witness from Advanced Surgical Associates, LLC	Date

ssa54

ADVANCED SURGICAL ASSOCIATES, LLC
2451 INTELLIPLEX DRIVE, SUITE 280
SHELBYVILLE, IN 46176
Phone: 317-392-0222 Fax: 317-392-0722

Express Consent to Communication

The undersigned ("you" or "your") hereby gives express consent for Advanced Surgical Associates, LLC ("creditor") to contact you at the phone numbers and emails listed below in connection with your business relationship with creditor. The term "contact" includes landline and cellular telephone communications, leaving voice mails or answering machine messages, leaving messages with persons who answer phones authorized by you, text message communications, email message communications, and similar methods of communication. This express consent also authorizes such communications to be sent by automated dialers and messaging equipment. This express consent also applies to any phone numbers and emails you provide in the future whether you provide such phone numbers and emails in writing or verbally. This express consent also allows any agents, contractors, or attorneys of creditor to contact you at the phone numbers or emails you provide to creditor for the purpose of resolving any unpaid balances owed to creditor. You may cancel this consent at any time by notifying creditor or, if applicable, by notifying an agent, contractor, or attorney of creditor that is in current contact with you.

Signature _____ Date _____

Printed Name _____

Authorized
Phone Number _____

Authorized
Phone Number _____

Authorized Email _____

ADVANCED SURGICAL ASSOCIATES, LLC
2451 INTELLIPLEX DRIVE, SUITE 280
SHELBYVILLE, IN 46176
Phone: 317-392-0222 Fax: 317-392-0722

CONSENT TO MEDICAL TREATMENT, MEDICAL PROCEDURES, SURGERIES, ANESTHESIA, RELEASE OF PHARMACY INFORMATION, AND BILL MEDICAL INSURANCE.

PATIENT NAME _____ DATE _____

I, the undersigned patient, or patient's legal representative, understand and consent Tiong Oen Pouw M.D., F.A.C.S, Carlos A. Vieira M.D., F.A.C.S, George M. Wairiuko M.D., F.A.C.S, and Shotaro Sano D.O., to diagnose and treat my medical condition.

I, the undersigned patient, or patient's legal representative, understand and consent Tiong Oen Pouw M.D., F.A.C.S, Carlos A. Vieira M.D., F.A.C.S, George M. Wairiuko M.D., F.A.C.S, and Shotaro Sano D.O., to perform medical and surgical procedures considered necessary in accordance with generally acceptable standards of medical practice for the particular type of medical treatment involved. I understand the risks, impose no specific limitation, and hold the providers and staff of Advanced Surgical Associates LLC harmless.

I, the undersigned patient, or patient's legal representative, consent to the administration of anesthesia for minor medical office surgical procedures.

I, the undersigned patient, or patient's legal representative will have my medical condition, treatment plan, complications, and risks associated with the disease process explained to me.

I, the undersigned patient, or patient's legal representative consent Advanced Surgical Associates LLC to discuss and send my appropriate medical records to my referring physician and/or treating providers, medical facilities, and insurance providers.

I, the undersigned patient, or patient's legal representative understand the above consent and authorize the medical providers of Advanced Surgical Associates LLC to provide and administer medical treatment for my medical condition and to have access to my pharmacy information. I give consent for Advanced Surgical Associates LLC to file my insurance for medical services, procedures, and surgeries rendered. I also understand that I will be considered the responsible billing party that is liable for any copayments, deposits, or balances left outstanding on this account after appropriate insurance filing. Should any balance go unpaid, I agree to be the responsible billing party for any collection fees including but not limited to collection agency fees, attorney fees, and court costs incurred while collecting this account.

Consent/Financial Guarantor Signature _____

ADVANCED SURGICAL ASSOC, LLC.

Constitutional

weight change	O Yes	O No
loss of appetite	O Yes	O No
fever	O Yes	O No
weakness	O Yes	O No
bleeding problems	O Yes	O No
fatigue	O Yes	O No
night sweats	O Yes	O No

Cardiology

shortness of breath	O Yes	O No
palpitations	O Yes	O No
dizziness	O Yes	O No
chest pain	O Yes	O No
edema	O Yes	O No

Genitourinary male

increased urinary frequency	O Yes	O No
difficulty urinating	O Yes	O No
hernia	O Yes	O No
kidney disease	O Yes	O No

ENT/Respiratory

cold	O Yes	O No
cough	O Yes	O No
nose bleed	O Yes	O No
sore throat	O Yes	O No

Gastroenterology

difficulty swallowing	O Yes	O No
abdominal pain	O Yes	O No
nausea	O Yes	O No
vomiting	O Yes	O No
constipation	O Yes	O No
diarrhea	O Yes	O No
blood in stool	O Yes	O No
change in bowel habits	O Yes	O No
heartburn	O Yes	O No

Musculoskeletal

joint swelling	O Yes	O No
joint pain	O Yes	O No
leg cramps	O Yes	O No

Genitourinary female

vaginal discharge	O Yes	O No
difficulty urinating	O Yes	O No
increased urinary frequency	O Yes	O No
pelvic pain	O Yes	O No

Endocrinology

excessive thirst	O Yes	O No
excessive urination	O Yes	O No
weight loss	O Yes	O No
cold intolerance	O Yes	O No
heat intolerance	O Yes	O No

Ophthalmology

diminished vision	O Yes	O No
blurring of vision	O Yes	O No
loss of vision	O Yes	O No

Psychology

depression	O Yes	O No
sleep disturbances	O Yes	O No
mental /physical abuse	O Yes	O No
anxiety	O Yes	O No

Dermatology

keloid formation	O Yes	O No
skin cancer	O Yes	O No
moles	O Yes	O No
bruising	O Yes	O No

Neurology

seizures	O Yes	O No
memory loss	O Yes	O No
dizziness	O Yes	O No

Hematology

easy bleeding	O Yes	O No
bruising	O Yes	O No
swollen glands	O Yes	O No

ADVANCED SURGICAL ASSOC, LLC.

Social History

alcohol	O Yes O No
recreational drugs	O Yes O No
smoking	O Yes O No

Past Medical History

high blood pressure	O Yes O No
high cholesterol	O Yes O No
diabetes	O Yes O No
CHF	O Yes O No
COPD	O Yes O No
Heartburn/reflux	O Yes O No
asthma	O Yes O No
Cancer	O Yes O No

Family History

Cancer	O Yes O No
Heart Disease	O Yes O No
Diabetes	O Yes O No
Lung Disease	O Yes O No

Surgical History

hysterectomy	O Yes O No
inguinal hernia repair	O Yes O No
ventral hernia repair	O Yes O No
gallbladder removed	O Yes O No
appendectomy	O Yes O No
umbilical hernia repair	O Yes O No
duodenal ulcer repair	O Yes O No
tonsil's removed	O Yes O No
prostate surgery	O Yes O No
coronary artery bypass	O Yes O No
heart cath	O Yes O No
colonoscopy	O Yes O No
gastric bypass	O Yes O No
gastric stapling	O Yes O No
colon resection	O Yes O No
heart stent	O Yes O No
joint Replacement	O Yes O No