

CRL Surgical Associates

Patient Social Security #: _____ DOB: _____

First, Middle Initial & Last Name: _____

Maiden Name (If Applicable): _____

Address: _____

City/State/Zip Code: _____

Home Phone () _____ Work Phone () _____ Cell () _____

Patient Gender: Male Female Marital Status: S M D W SO Other _____

Insurance Company: _____

Subscriber Name: _____ SS#: _____ - _____ - _____ DOB: ____/____/____

Subscriber Address: _____

Subscriber Phone #: _____

Patient Employer: _____ Occupation: _____

List all allergies including latex, drug, food, etc. _____

Primary Care Physician: _____ Referring Physician: _____

Chief Complaint: _____

How were you referred to us: Primary Care Physician Website Magazine Other _____

With whom do we have permission to discuss your medical care:

1. _____ Relationship _____ Phone # _____
2. _____ Relationship _____ Phone # _____

I authorize direct payment of my insurance benefits to Dr.'s Latham B. Murray, Lewis V. Owens, and John Ligush (DBA Charlottesville Radiology, Ltd., CRL Surgical Associates) for professional services rendered. I accept responsibility for payment of all charges incurred as well as all collection agency costs and/or attorneys fee up to 33 1/3 % should such collection action become necessary. I also understand that my co-payment is due at the time of service.

I authorize the release of my medical information necessary to process claims for services rendered to me by Dr.'s Latham B. Murray, Lewis V. Owens, and John Ligush (DBA Charlottesville Radiology, Ltd., CRL Surgical Associates).

Signature: _____ Date: _____
Signature: _____ Date: _____
Signature: _____ Date: _____
Signature: _____ Date: _____
Signature: _____ Date: _____

HEALTH ASSESSMENT

Please take a brief moment to complete this form to the best of your ability. The Health Assessment serves as an important component of your complete medical record. Any information you give is voluntary and will be kept strictly confidential. Thank you.

Name _____ Date _____

Age _____ Sex _____ Medical doctor _____

Height _____ ft _____ in Weight _____ lbs

Medical Conditions:

Heart Disease	Y	N	Lung Disease	Y	N
High Blood Pressure	Y	N	Kidney Disease	Y	N
Diabetes	Y	N	Vascular Disease	Y	N
High Cholesterol	Y	N	Other (List) _____		

Drug Allergies _____

Medications (Drug and dosing schedule) _____

Prior Surgical Procedures: _____

Health Survey- Do you currently have or have you recently had any of the conditions listed below? Please circle yes or no.

General

Weight loss Yes No
 Loss of appetite Yes No

Eyes

Glasses Yes No
 Blurred vision Yes No
 Blindness Yes No
 Double vision Yes No

Ears

Pain Yes No
 Infections Yes No
 Hearing loss Yes No
 Vertigo Yes No

Neck

Hoarseness Yes No
 Difficulty swallowing Yes No
 Lumps Yes No
 Thyroid problems Yes No
 Neck radiation Yes No

Chest

Shortness of breath Yes No
 Chronic cough Yes No
 Wheezing Yes No
 Sputum production Yes No

Infections

Tuberculosis Yes No
 Hepatitis Yes No

Cardiovascular

Chest pain Yes No
 Irregular heart beat Yes No
 Palpitations Yes No
 Heart attack Yes No
 Pacemaker Yes No

Gastrointestinal

Nausea/vomiting Yes No
 Diarrhea Yes No
 Blood in stool Yes No
 Constipation Yes No

Extremities

Pain when walking Yes No
 Pain at rest Yes No
 Pain at night Yes No
 Cramps Yes No
 Ulcers/wounds Yes No
 Blood clots Yes No
 Varicose veins Yes No

Neurologic

Unstable Walking Yes No
 Numbness in arms/legs Yes No
 Weakness in arms/legs Yes No

Blood

Bleeding problems Yes No
 Clotting disorder Yes No

Psychiatric

Yes No