

Print these forms to complete.

Granville Surgical Associates

Michael E. Wegener, M.D., F.A.C.S.
103-B Professional Park Drive
Oxford, NC 27565

(919)603-0368
(919)603-0842 - fax
gsa@granvillemedical.com

Patient Information

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information is confidential.

DATE PATIENT NAME SEX: M / F BIRTH DATE
SS#/SIN DRIVERS LICENSE # MARITAL STATUS
HOME ADDRESS CITY STATE/PROV ZIP/P.C.
PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER OCCUPATION
WORK ADDRESS CITY STATE/PROV ZIP/P.C.
IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE CITY STATE/PROV
HOME PHONE ()
WORK PHONE ()
CELL PHONE ()
E-MAIL
PERSON TO CONTACT IN CASE OF EMERGENCY PHONE ()

Responsible Party

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT RELATION TO PATIENT
HOME ADDRESS CITY STATE/PROV ZIP/P.C.
WORK ADDRESS CITY STATE/PROV ZIP/P.C.
HOME PHONE () WORK PHONE () CELL PHONE ()
DRIVER'S LICENSE # BIRTH DATE IS THIS PERSON CURRENTLY A PATIENT AT OUR OFFICE: YES / NO

Insurance Information

NAME OF INSURED RELATION TO PATIENT
BIRTH DATE SS#/SIN
NAME OF EMPLOYER WORK PHONE
ADDRESS OF EMPLOYER CITY STATE/PROV ZIP/P.C.
INSURANCE COMPANY GROUP # POLICY# INS CO PHONE ()
INS. CO ADDRESS CITY STATE/PROV ZIP/P.C.
HOW MUCH IS YOUR DEDUCTIBLE? \$ HOW MUCH HAVE YOU USED? \$ MAX ANNUAL BENEFIT \$

Do you have any additional (secondary) insurance? Yes / No If yes, complete the following:

NAME OF INSURED RELATION TO PATIENT
BIRTH DATE SS#/SIN
NAME OF EMPLOYER WORK PHONE
ADDRESS OF EMPLOYER CITY STATE/PROV ZIP/P.C.
INSURANCE COMPANY GROUP # POLICY# INS CO PHONE ()
INS. CO ADDRESS CITY STATE/PROV ZIP/P.C.
HOW MUCH IS YOUR DEDUCTIBLE? \$ HOW MUCH HAVE YOU USED? \$ MAX ANNUAL BENEFIT \$

I authorize release of any information concerning my (my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

Signature of patient or parent/guardian if minor

Date

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Health History – Confidential

There are five (5) total pages to this form. Please sign the first and last pages and fill in as much information as you are able. If you have any questions about this form, please ask the receptionist or the doctor before you leave today.

Name: _____ Today's Date: _____

Birth Date: _____ Age: _____ Height: _____ Weight: _____

Primary Care Doctor: _____

Do you see any other doctors? Y / N
Doctor's Name Why do you see this doctor?

DO YOU HAVE A LIVING WILL? Y / N
Please provide a copy if you have one.

ARE YOU AN ORGAN DONOR? Y / N

WHO MAY WE GIVE OUT YOUR MEDICAL INFORMATION TO?

- Myself
- Spouse
- Parents
- Other: _____

WHAT IS YOUR RELIGION? _____

WHAT IS THE REASON YOU ARE COMING TO SEE THE DOCTOR?

Patient Signature: _____ Date: _____

PLEASE SIGN THIS PAGE

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PLEASE LIST THE MEDICATIONS YOU ARE PRESENTLY TAKING:

I DO NOT TAKE ANY MEDICATIONS PRESENTLY (CHECK HERE)

NAME

DOSE

FREQUENCY

PLEASE LIST ANY "OVER THE COUNTER" MEDICATIONS YOU ARE TAKING:

I DO NOT TAKE ANY OVER THE COUNTER MEDICATIONS (CHECK HERE)

NAME

DOSE

FREQUENCY

Do you take any steroids: Y / N

Do you take aspirin daily: Y / N

Do you take any blood thinners: Y / N

Do you take antibiotics for dental procedures: Y / N

PLEASE LIST ANY MEDICATION ALLERGIES THAT YOU HAVE:

I DON'T HAVE ANY MEDICATION ALLERGIES (CHECK HERE)

MEDICATION

REACTION

PLEASE LIST ANY PREVIOUS SURGERIES:

I HAVE NEVER HAD SURGERY BEFORE (CHECK HERE)

PROCEDURE

DATE

WHY DID YOU HAVE THIS SURGERY?

Do you have any metal implants: Y / N

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HAVE YOU HAD ANY X-RAYS DONE RECENTLY? Y / N
Type Where Done

HAVE YOU TRAVELED OUTSIDE THE U.S. RECENTLY? Y / N
If so, where? _____

DO YOU SMOKE? Y / N
If yes, how many packs per day_____ How many years_____
If you quit, how long ago?_____

DO YOU DRINK ALCOHOL? Y / N
If yes, how much?_____

DO YOU TAKE ANY STREET DRUGS? Y / N
Which ones? _____

DO YOU HAVE SLEEP APNEA? Y / N
Do you use a CPAP Machine? Y / N
Do you wake up at night out of breath? Y / N
Do you Snore? Y / N

FAMILY HISTORY:

Any history of cancer in your family Y / N
If yes: Relation Type of Cancer

Any other family medical problems Y / N
If yes, please describe:

CHECK IF YOU HAD ANY OF THE FOLLOWING SYMPTOMS IN THE PAST YEAR:

- | | | | |
|---|---|--|---|
| General | Gastrointestinal | Eye/Ear/Nose/Throat | Men only |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Breast lump |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Appetite poor | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Erection difficulties |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Bloating | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Lump in testicles |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Bowel Changes | <input type="checkbox"/> Change in voice | <input type="checkbox"/> Penis discharge |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Constipation | <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Sore on penis |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Testicular pain |
| <input type="checkbox"/> Forgetful | <input type="checkbox"/> Excessive Hunger | <input type="checkbox"/> Double Vision | Women only |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Earache | <input type="checkbox"/> Abnormal Pap smear |
| <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Gas | <input type="checkbox"/> Ear discharge | <input type="checkbox"/> Bleeding between periods |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Breast lump |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Extreme menstrual pain |
| <input type="checkbox"/> Sweats | <input type="checkbox"/> Stomach Pain | <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Irregular menstrual period |
| Muscle/Joint/Bone | <input type="checkbox"/> Vomiting Blood | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Nipple discharge |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Ulcer disease | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Cold extremities | Cardiovascular | <input type="checkbox"/> Sinus problems | Neurological |
| <input type="checkbox"/> Difficulty Walking | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Swollen glands in neck | <input type="checkbox"/> Convulsions or seizures |
| <input type="checkbox"/> Joint stiffness /swelling | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Visual flashes | <input type="checkbox"/> Head Injury |
| Pain, weakness, numbness in: | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Visual halos | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Arms <input type="checkbox"/> Hips | <input type="checkbox"/> Low blood pressure | Skin | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back <input type="checkbox"/> Legs | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Tingling or numbness |
| <input type="checkbox"/> Feet <input type="checkbox"/> Neck | <input type="checkbox"/> Rapid heart beat | <input type="checkbox"/> Change in hair or nails | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders | <input type="checkbox"/> Swelling of ankles | <input type="checkbox"/> Change in moles | Endocrine |
| Genito-Urinary | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Change in skin color | <input type="checkbox"/> Change hat or glove size |
| <input type="checkbox"/> Blood in urine | Respiratory | <input type="checkbox"/> Hives | <input type="checkbox"/> Excessive thirst |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Itching | <input type="checkbox"/> Excessive urination |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Rash | <input type="checkbox"/> Hot or cold intolerance |
| <input type="checkbox"/> Lack of bladder control | <input type="checkbox"/> Spitting up blood | <input type="checkbox"/> Scars | <input type="checkbox"/> Skin becoming dryer |
| <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Sore that won't heal | <input type="checkbox"/> Other _____ |

CHECK IF YOU HAVE EVER HAD ANY OF THE FOLLOWING CONDITIONS:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Leg Ulcers | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Measles | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gout | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hernia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Transfusion |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Venereal Disease |

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Date of Last Menstrual Period:
Age when menstrual periods started:
Do you still have regular menstrual periods Y / N
If no, how old were you when they stopped:
How many times have you been pregnant ____
How many children do you have ____
Do you or did you ever take birth control pills Y / N
If so, for how long? _____
Do you or did you ever take hormone replacement Y / N
If so, for how long? _____
Menstrual Problems Y / N
If yes, please describe:

Date of last Pelvic Exam: _____
Date of Last Mammogram: _____
Do you perform a self-breast exam? Y / N

PEDIATRIC PATIENTS:

Does/did the child use an Apnea monitor? Y / N
Was the child premature? Y / N
How many weeks? ____
Any congenital health problems? Y / N
If yes, please explain:

Are all vaccinations up to date? Y / N

Patient Signature:_____ Date:_____

Physician Review:_____ Date:_____

PLEASE SIGN THIS PAGE

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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that a copy of the Granville Surgical Associates Notice of Privacy Practices has been provided to me. The notice contains information regarding potential uses and disclosures of my protected health information (as that term is defined under the Health Insurance Portability and Accountability Act of 1996 "HIPPA") that may be made by Granville Surgical Associates, and of my rights and Granville Surgical Associate's legal duties with respect to my protected health information. I have had the opportunity to review the Notice and take a copy with me if I so choose.

Patient's Name

Patient's Signature

Date

Disclosure Authorization:

I give permission that Granville Surgical Associates may:

- Leave a detailed message on my home answering machine or voice mail
- Leave a verbal detailed message with my spouse
- Call my workplace phone number and leave a message
- Call my workplace phone number and speak to me only
- May discuss my condition(s) with _____
- None of the above

Instructions for filling out *GSA* New Patient Forms

Please be sure to sign and date pages 1, 2,6 and 7. (Page 6 must still be signed by male patients, even though that page pertains to women and children).

A complete copy of the *GSA* Notice of Privacy Practices will be provided to you upon arrival at Granville Surgical Associates.

If you have any questions about these forms, please call the office at 919-603-0368, Monday through Friday, from 9 - 5. Completing these forms and bringing them with you will be very helpful for both you and our office staff. We thank you in advance for taking the time to do this.