Bala "Vish" Viswanathan
Diplomate American Board of Surgery

19260 Stone Oak Parkway, Suite 102
San Antonio, Texas 78258

Patient History Form

DATE: _____

PATIENT: _____ **REFERRING PHYSICIAN:** _____

CHIEF COMPLAINTS: _____

MEDICAL HISTORY: Do you have: □ Hypertension □ Diabetes □ High Cholesterol □ Hypothyroidism □ Acid Reflux □ Asthma/COPD □ Epilepsy □ Stroke □ Heart Attack □ Cancer □ Bleeding Disorder □ Depression/Anxiety □ Other_____

Are you pregnant **Yes/No** If Yes, How long? _____ How many pregnancies? _____Year(s)_____

SURGICAL HISTORY: 1._____Year:_____ 2._____Year:_____
3._____Year:_____4._____Year:_____ 5. _____Year:_____

MEDICATIONS:

1._____mg_____
2._____mg_____
3. _____mg_____
4. _____mg_____
5. _____mg_____
6. _____mg_____

DRUG ALLERGIES:

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

PERSONAL AND SOCIAL HISTORY: *SMOKING:* **Yes/No** If Yes, How Much_____How Long_____
ALCOHOL: **Yes/No** If Yes, How Much_____How Long_____
*SUBSTANCE ABUSE:*_____

FAMILY HISTORY:

Father's Side □ Hypertension □ Diabetes □ Cancer □ Other_____
Mother's Side □ Hypertension □ Diabetes □ Cancer □ Other_____
Sibling(s): □ Hypertension □ Diabetes □ Cancer □ Other_____

□ Read and Reviewed by Dr.Viswanathan

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Registration Form

Patient Information

Name:_____ D.O.B:_____ Age:_____ Today's Date:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone #:_____ Cell Phone #:_____ Work Phone #:_____

E-Mail Address:_____ Social Security #:_____

Employer:_____ Occupation:_____

Sex □ F □ M Marital Status: □ Single □ Married □ Divorced Spouse:_____

Insurance Information

Primary Insurance:_____ ID#:_____ Group#:_____

Secondary Insurance:_____ ID#:_____ Group#:_____

Policy Holder:_____ Relationship to Patient:_____

Policy Holder D.O.B.: _____ Policy Holder Social Security #:_____
(if different from patient, such as a spouse or legal guardian)

Patient's Primary Care Physician:_____ Referral # (if any):_____

Emergency Contact:_____ Phone #:_____ Relationship:_____

Authorization and Assignment of Benefits
please read carefully and sign

I hereby authorize and assign payment of benefits by my insurance carrier to be paid directly to Dr. Bala Viswanathan for services rendered. I also understand that I will be responsible for any co-pays, deductibles and any other charges that are not covered by my insurance. In the case of no insurance coverage, I will be responsible for all charges incurred during the course of my treatment.

Appointment cancellations not made 24 hours in advance will be charged a fee of $25.00 that can be paid by cash, check or credit during the next visit.

I acknowledge that I have read and received the *HIPPA Notice of Privacy* **and** that I have read and understood the Assignment of Benefits provided above.

Signature: _____ Date: _____
(patient or parent/legal guardian if patient is under 18 years old)

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Medical Release Form

To Physician or Hospital: _____

Address: _____

City/State/Zip Code: _____
(the above can be filled out by our office if a records request is necessary)

I hereby authorize and request that you release all complete medical history and records in your possession concerning my illness, injury and/or treatment during the period from _____-_____ to Bala Viswanathan, M.D., at 19260 Stone Oak Parkway, Suite #102, San Antonio, Texas 78258

Please Print Clearly

Name of Patient:_____

Social Security #: _____ D.O.B.:_____

Signature:_____ Today's Date:_____
(patient or parent/legal guardian if patient is under 18)

these records can be faxed to Dr.Viswanathan's office at (210)545-0222
or mailed to the above address.

I hereby authorize Dr. Bala Viswanathan to release any records acquired in the course of my treatment to any physician, medical facility or insurance carrier as needed (i.e.) pre-operative test results before surgery, pathology and operative reports (etc.) or any other records required by any of my treating physicians, medical facilities or my insurance carrier.

Signature:_____ Today's Date:_____
(patient or parent/legal guardian if patient is under 18)

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Diplomate American Board of Surgery

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Treatment Authorization Form

I hereby authorize medical treatment by Dr. Bala Viswanathan for any surgery that is needed for my spouse, my child, or me. This authorization also includes the use of an assistant surgeon if needed, as some surgeries require the use of an assistant surgeon either by hospital mandate or because of the type of surgery being performed. You will probably not meet this assistant surgeon because he or she will be called in after surgery begins. However, you will receive a separate bill from his or her office. If you have any questions regarding your surgery and whether it will require an assistant surgeon, please discuss this with our office or with Dr. Bala Viswanathan.

I agree to the treatment/treatments recommended by Dr. Bala Viswanathan and to any assistant required, chosen by Dr. Bala Viswanathan.

Signature:_____ Today's Date:_____
(patient or parent/legal guardian if patient is under 18)

Witness:_____ Today's Date:_____

Surgeries requiring an assistant include but are not limited to:

- *Laparoscopic Cholecystectomy (gallbladder surgery)*
- *Mastectomy with or without reconstruction*
- *Any colon surgery*
- *Gastrectomy (stomach removal-partial or complete)*
- *Hernia repair surgeries*
- *Thyroid surgery*

This form must be signed before any surgical procedure can be scheduled