PIKE MEDICAL CONSULTANTS

URGENTCARE | WEIGHTCARE | GERICARE

PULMONARY | OCCUPATIONAL HEALTH | COUNSELING SERVICES

Physicians - Dr. James D. Pike

Providers - Larry Vandermolen PA-C, Heather Foxworthy ANP-BC

Dear _____,

Your surgeon has referred you to our office so that we may perform a preoperative assessment prior to your upcoming procedure. You will meet with one of our providers for a detailed medical history and brief physical exam, including electrocardiogram and blood work. Please take your usual medications and eat in your usual manner before your visit. Our goal is to provide you with the safest environment possible for your procedure and your recovery. **The visit to our office will be approximately 1 to 2 hours long.**

PLEASE BRING:

- **Insurance cards and a photo identification.**
- **Completed preoperative history forms (attached).**
- A **current list of medications** (including dose and frequency). Remember to include insulin, inhalers, eye drops, vitamins, and herbal preparations.
- **IF APPLICABLE, any cardiac testing reports and/or other procedure notes** within the past five years (this includes: electrocardiograms, stress testing, laboratory testing, etc.). You may also have these faxed to our office by your physician.

Your Appointment is on_____, _____ at _____.

Please arrive at _____.

You may be asked to reschedule if you are more than 15 minutes late for your arrival time. If you are required by your insurance policy to pay an office visit copay we will collect it at the time of registration.

If you have any questions, please call our office between the hours of 9am and 4pm. We look forward to treating you at our preoperative center.

"The best care, the best way, each day, with compassion, devotion, and respect."

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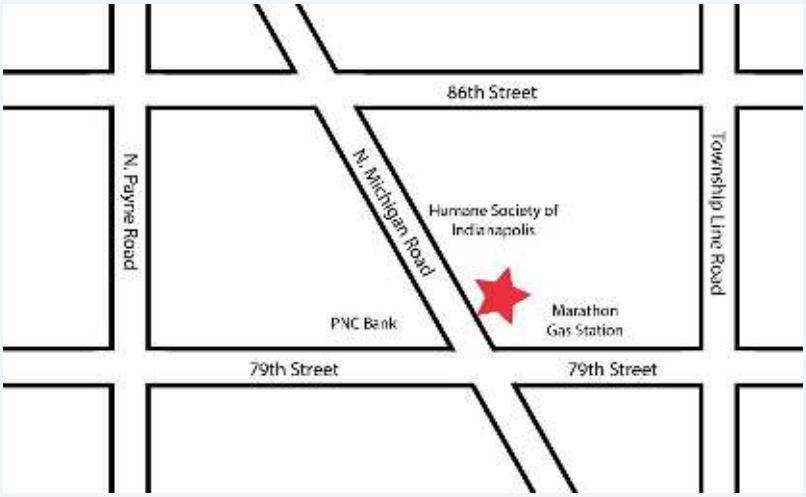
7911 N. Michigan Road Indianapolis, IN 46268 | 317.956.6288 | pikemedical.com



Pike Medical Consultants is located at 79th and Michigan Rd.

If North of Indianapolis	If South of Indianapolis	If East of Indianapolis	If West of Indianapolis
- Take I-65 South - Merge onto I-865 E - Merge onto I-465 S - Take exit 27, Michigan Road - Turn right off the exit ramp - Continue on Michigan Road/US-421 N. - Destination is on the left just before 79th street	- Take I-74 West to I-65 North - Take exit 116 toward 30th St. - Merge onto W. 30th St. via the ramp on the left toward Indianapolis Museum of Art/Butler Univ. - Turn right onto Martin Luther King Jr. St. This becomes Michigan Rd. - Destination is on the right	- Take I-70 W or 69 S - Merge to 65 N. via exit 83B - Take exit 116 toward 30th St. - Merge onto W. 30th St. via the ramp on the left toward Indianapolis Museum of Art/Butler Univ. - Turn right onto Martin Luther King Jr. St. This becomes Michigan Rd. - Destination is on the right	- Take US I-70 or I-74 East - Merge onto I-465 N - Take exit 21 onto 71st St. - Keep left to take the 71st St. ramp - Turn right onto 71st St. - Turn left onto Michigan Road - Destination is on the right

Pike Medical Consultants Preoperative Evaluation

PLEASE COMPLETE ALL SECTIONS PRIOR TO YOUR APPOINTMENT

Patient Name _____ **Date of Birth _____**

Primary Care Physician_____ Pharmacy Name_____ Phone (____)_____

Other Specialists (include type)_____

Have you been seen by Pike Medical before? ☐ No ☐ Yes When? _____

Past Medical History

☐Abdominal Pain	☐Dementia	☐Hernia	☐Prostate Problems
☐Allergies	☐Depression	☐HIV	☐Recent Urinary Tract Infection
☐Anemia	☐Diabetes	☐High Blood Pressure	☐Rheumatic Fever
☐Asthma	☐Diarrhea	☐High Cholesterol	☐Rheumatoid Arthritis
☐Anxiety	☐Dizziness/Vertigo	☐High Triglycerides	☐Seizure disorder
☐Atrial Fibrillation	☐Emphysema/COPD	☐Infections	☐Skin Problems
☐Bleeding Disorder	☐Fibromyalgia	☐Insomnia	☐Sleep Apnea (CPAP use Y/N)
☐Blood Clot (DVT or PE)	☐Gastroesophageal Reflux	☐Kidney Failure	☐Staph infections/MRSA
☐Bowel Obstruction	☐Glaucoma	☐Kidney Stones	☐Stroke/TIA
☐Cancer	☐Gout	☐Liver Disease	☐Thyroid Disease
☐Chronic Cough	☐Heart Disease (heart attack, stent, bypass)	☐Lupus	☐Ulcers
☐Colitis/Crohn's Disease		☐Mononucleosis	☐Vascular Disease
☐Congestive Heart Failure	☐Hemorrhoids	☐Murmur	
☐Constipation	☐Hepatitis	☐Pneumonia	

Patient Name _____

Previous Heart Testing

TEST	WHERE	WHEN	WHY WAS IT DONE?	RESULTS, IF KNOWN
EKG				
Echocardiogram				
Stress Test				
Heart Cath				
Who is your cardiologist?				
When were you last seen?				

Current Medications ☐ List is attached

Name	Dose	Frequency

Herbs, Supplements and Vitamins

_____
_____
_____
_____

Allergies

Medication Allergy	Reaction

Past Surgical History **Would you accept blood products or blood transfusions if necessary? ☐Yes ☐No**

Surgery	Date	Surgeon	Hospital	Outcome	Complications?

Patient Name _____

Social History

	Type	Quantity Daily	Years of Use	Ever Tried to Quit (Y/N)? When?	Ever Had Withdrawal (Y/N)?
Tobacco					
Drugs					
Marital Status	☐Single	☐Married	☐Divorced	☐Widowed	
Exercise	☐Very Physically Active	☐Moderately Active	☐Inactive		
Occupation					
Religion					

Alcohol Use

Circle the type of alcohol you typically consume and indicate below the quantity daily

Beer	Malt Liquor Craft Beer	Table Wine Sparkling Wine	Sherry/Port	Cordial/Aperitif	Brandy	Hard Liquor
12 fl oz	8-9 fl oz	5 fl oz	3-4 oz	2-3 oz	1.5 oz	1.5 fl oz
						
5% alcohol	7% alcohol	12% alcohol	17% alcohol	24% alcohol	40% alcohol	40% alcohol

Have you ever had symptoms of alcohol withdrawal (seizures, shaking, jitteriness)? ☐Yes ☐No

Family History

	Living or Deceased (Age of death)	Heart Disease (include details and age at onset)	Stroke	Cancer	Blood Clot	Diabetes	Other Inherited Illness
Mother							
Father							
Siblings							
Children							

Anxiety/Depression

Have you ever been treated for anxiety or depression? ☐Yes ☐No If so, when? _____ Currently in treatment? ☐Yes ☐No

Are you anxious about your upcoming surgery? ☐Yes ☐No

Have you experienced depression following your past surgeries? ☐Yes ☐No

Would you like to talk with our counselor about your feelings? ☐Yes ☐No

Patient Name _____

Bone Health

Have you ever had a bone density (DEXA) test? ☐Yes ☐No

Where_____ When_____ Results: ☐Normal ☐Osteopenia ☐Osteoporosis

Are you currently being treated for Osteopenia or Osteoporosis?
☐No
☐Yes Medication_____ How long have you taken it?_____

Have you broken a bone in your adult life? ☐Yes ☐No
Location of break_____ How did you break it?_____

Have you lost more than 1 ½ inches (women) or 2 inches (men) in height? ☐Yes ☐No
Did anyone related to you break their hip or spine? ☐Yes ☐No Details_____

Within the Past 12 Months, Have You Had

☐Fever	☐Chills	☐Feeling Poorly	☐Feeling Tired	☐Weight Gain	☐Weight Loss
☐Eye Pain	☐Eye Redness	☐Vision Change	☐Eye Discharge	☐Dry Eyes	☐Itchy Eyes
☐Earache	☐Hearing Loss	☐Nosebleeds	☐Nasal Discharge	☐Sore Throat	☐Hoarseness
☐Chest Pain	☐Slow Heart Rate	☐Fast Heart Rate	☐Palpitations	☐Leg Swelling	
☐Wheezing	☐Cough	☐Snoring	☐Shortness of Breath	☐Shortness of Breath on Exertion	
☐Abdominal Pain	☐Nausea	☐Vomiting	☐Constipation	☐Diarrhea	☐Heartburn
☐Bloody Stool	☐Tarry Stool	☐ Stool Incontinence			
☐Urinary Burning	☐Pelvic Pain	☐Urine Incontinence	☐Urinary Infection	☐Urinary Frequency	☐Urinary Retention
☐Skin Lesions	☐Skin Wounds	☐Skin Infections	☐Dry Skin	☐Itching	☐Change in a Mole
☐Breast Pain	☐Breast Lump				
☐Confusion	☐Convulsions	☐Dizziness	☐Fainting	☐Weakness	
☐Suicidal Thoughts/Attempts		☐Insomnia	☐Anxiety	☐Depression	
☐Easy Bleeding	☐Easy Bruising	☐Blood Clots	☐Swollen Glands		

Additional Information

To the best of my knowledge, all of the above statements are true and accurate.

Patient Signature _____ Date _____

Reviewed By _____

PLEASE COMPLETE ALL SECTIONS PRIOR TO YOUR APPOINTMENT **PATIENT REGISTRATION**

Patient Information

First Name	Middle Initial(s)	Last Name	
Street Address	City	State	Zip Code
Date of Birth	Primary Phone Number	Secondary Phone Number	
Social Security Number	□ Male □ Female	Email Address	
What is your preferred method of contact? □ Phone □ Email		May we leave a message? □ Yes □ No	
Marital Status □ Single □ Married □ Divorced □ Widowed		Preferred Language □ English □ Spanish □ Other:	
Race □ Asian □ Black or African American □ Native American □ White □ Other:		Ethnicity □ Hispanic or Latino □ Not Hispanic or Latino	
Current Employer or Employment Status	City	State	Phone Number
How did you hear about us: □ Physician Referral □ Internet: Google/Bing/Yahoo □ Word of Mouth □ 86th Street Sign □ KLOVE □ Other:			
Emergency Contact Name		Phone Number	Relation to Patient
Family Physician Name	Physician Phone Number	Preferred Pharmacy	Pharmacy Phone Number
If necessary, may we verify your prescriptions with pharmacy records? □ Yes □ No			

Current Billing Information

Responsible Party's Name □ Self		Relationship to Patient	Date of Birth
Street Address		City	State / Zip Code
□ I do not currently have medical insurance (check box and skip to signature line)			
Primary Insurance Company		Group Number	Policy/ID Number
Policy Holder's Name	Date of Birth	Social Security Number	Relation to Patient
Employer	City, State and Zip Code		Phone Number
Secondary Insurance Company		Group Number	Policy/ID Number
Policy Holder's Name	Date of Birth	Social Security Number	Relation to Patient
Employer	City, State and Zip Code		Phone Number
Prescription Plan Name (if applicable)	Prescription Plan ID Number		Contact Number

Authorization and Assignment

(APPLIES TO MEDICARE PATIENTS ONLY) I request that payment of authorized MEDICARE benefits be made either by me or on my behalf to provide for any services furnished to me by a medical provider. I authorize the holder of my medical information to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

(APPLIES TO MEDIGAP PATIENTS ONLY) I request that payment of authorized MEDIGAP benefits be made either by me or on my behalf to provide for any services furnished to me by a medical provider. I authorize any holder of medical information about me to release to my MEDIGAP insurance any information needed to determine these benefits payable for related services.

ALL PATIENTS/GUARANTORS: I hereby authorize the release of any medical information necessary to process any and all of my claims, or facts concerning the treatment provided. I further authorize my insurance company to pay direct to the medical provider, the medical benefits otherwise payable to me. I understand that I am financially responsible for those charges not paid by my insurance. If for any reason my account should become delinquent, I agree to pay for all collection and legal fees. A photocopy of this authorization shall be considered as valid as the original. This authorization shall remain valid until revoked by me or my legal representative.

Signature of Responsible Party **Today's Date** **v11/13**