BENRUS SURGICAL at BARNES JEWISH ST. PETERS PRIVACY POLICY INFORMATION

Do you authorize us to release any information to any other person or persons (spouse, friend, or roommate)? No information, such as test results or appointment changes, can be given to any other person unless listed. List name and relation:

1) _____
2) _____
3) _____

May we leave a detailed message regarding test results or other information on your voice mail?

Yes_____ No_____

If your disability insurance carrier requests information about you, either verbally or in writing, may we provide requested information?

Yes_____ No_____

Acknowledgement of Receipt of Privacy Notice

I have been given the opportunity to read a copy of **Benrus Surgical at Barnes Jewish St. Peters Notice of Privacy Policies,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____
_____
_____

Signed: _____ Date: _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ Witnessed by: _____

Benrus use only:
If patient or patient's representative refuses to sign acknowledgement of privacy notice, please document the date and time the notice was presented to the patient and sign below.

Presented on (date and time):_____

By (name and title): _____

BENRUS SURGICAL at BARNES JEWISH ST. PETERS
INFORMED CONSENT TO TREATMENT AND/OR SURGICAL PROCEDURE

It is very important to Benrus Surgical at Barnes Jewish St. Peters that you understand and consent to the treatment your doctor is rendering and any procedure your doctor may perform. You should be involved in any and all decisions concerning surgical procedures your doctor has recommended.

I hereby authorize the Physician(s) of Benrus Surgical at Barnes Jewish St. Peters or assistants to the doctor to provide treatment and/or procedures the physician deems appropriate and will discuss with me and/or my Authorized Representative. However, I understand there is no certainty I will achieve the benefits and no guarantee has been made to me regarding the outcome of the treatment and/or procedure(s). I also authorize the administration of sedation and/or anesthesia as may be deemed advisable or necessary for my comfort, well being and safety.

I understand there are risks and possible undesirable consequences associated with any procedure including, but not limited to, blood loss, transfusion reactions, infection, heart complications, blood clots, loss of or loss of use of body part, other neurological injury and/or death. I understand if I need blood or blood products these carry a risk of contracting HIV/AIDS, hepatitis or other diseases.

In permitting my doctor to provide treatment and/or perform the procedure(s), I understand unforeseen conditions may be revealed that may necessitate change or extension of the original procedure(s) or a different procedure(s) than those already explained to me. I therefore authorize and request the physician, his assistants, or his designees perform such procedure(s) as necessary and desirable in the exercise of his/her professional judgment.

In the unlikely event one or more of the above inherent complications may occur, my physician(s) will take appropriate and reasonable steps to help manage the clinical situation and be available to me and my family to address our concerns and questions.

I hereby authorize the doctor to utilize or dispose of removed tissues, parts or organs resulting from the treatment/procedure(s).

I consent to any photographing or videotaping of the procedure(s) performed, provided my identity is not revealed by the pictures or by descriptive texts accompanying them, so my physician may follow my therapy progression. I consent to the admittance of students or authorized equipment representatives to the procedure room for purposes of advancing medical education or obtaining important product information.

By signing below, I. the Patient/Authorized Representative have read this form or had it read to him/her. I also certify, as the Patient/Authorized Representative, that I (he/she) understand this information.

_____ _____

Signature of Patient/Authorized Representative Date/Time

_____ _____

Relationship, if other than patient signs Signature of Witness

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Certification of Physician:

I hereby certify I have discussed with the individual granting consent, the facts, anticipated benefits, material risks, alternative therapies and the risks associated with the alternatives of the treatment/procedure(s).

_____ _____

Signature of Physician Date/Time

Patient Demographic Form

In order to better serve our patients, and to update our records, please complete this basic information form:

Name: _____

Date of Birth: _____/_____/_____

Race:

__ Alaskan Native
__Asian
__Asian Pacific
__Black/African American (Not Hispanic)
__Hispanic
__Native American
__Other
__Pacific Islander
__Spanish American
__Unknown
__White /Caucasian (Not Hispanic)

Ethnicity: __Hispanic or Latino __Not Hispanic or Latino __Unknown

Preferred Spoken Language:

__Arabic
__Bulgarian
__Central Khmer
__Chinese
__English
__French
__German
__Haitian/Haitian Creole
__Hebrew
__Hindi
__Italian
__Japanese
__Korean
__Polish
__Portuguese
__Russian
__ Somali
__Spanish/Castilian
__Swahili
__Thai
__Urdu
__Vietnamese

__Other (Please specify) _____

BENRUS SURGICAL at BARNES JEWISH ST. PETERS

Today's Date: _____
Name: _____ Date of Birth: _____

Do you have an Advance Care Plan/Living Will: Yes No

Why are you seeing the doctor today? _____
Referring Physician: _____
Primary Care Physician: _____

MEDICATIONS:

Medication	Dose	How Often?	Side Effects

DRUG ALLERGIES:

_____
_____

REVIEW OF SYSTEMS:

Are you currently or have you had problems with your :

Describe all YES responses

Eye	No	Yes _____
Ears, Nose, Throat	No	Yes _____
Lungs/Breathing (COPD)	No	Yes _____
Stomach	No	Yes _____
Colon	No	Yes _____
Bladder (urination)	No	Yes _____
Diabetes	No	Yes _____
High Blood Pressure	No	Yes _____
Bleeding Problems	No	Yes _____
Heart	No	Yes _____
Asthma	No	Yes _____
Psychological Problems	No	Yes _____
AIDS	No	Yes _____
Cancer	No	Yes _____
Arthritis	No	Yes _____
Epilepsy	No	Yes _____
Other	No	Yes _____

_____

Reviewed by: _____ Date: _____
Physician's Signature

BENRUS SURGICAL at BARNES JEWISH ST. PETERS

NAME:_____ **Today's Date**_____
Date of Birth_____

PAST MEDICAL HISTORY

Surgeries / Hospitalizations Year Complications

_____
_____
_____
_____
_____
_____
_____

Have you had problems with general anesthesia? NO_____ YES_____
If yes Describe:_____

FAMILY HISTORY

Member	Alive	Deceased	Age	Health status or cause of death
Mother				
Father				
Sister				
Brother				
Sister				
Brother				

SOCIAL HISTORY

☐ Work in the home ☐ Employed (occupation) _____ ☐ Student

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

☐ Children ☐ Yes ☐ No Number of Children_____

HISTORY OF SUBSTANCE ABUSE? ☐ Yes ☐ No What? _____

☐ Smoke current? Number of packs per day _____ for _____years.

☐ Quit smoking ☐ this year ☐ > 1 year ☐ > 5years ☐ > 10 years

☐ Drink Alcohol ☐ Daily ☐ 1-2 x's per week ☐ 1-2 x's per month ☐ 1-2 x's year

Reviewed by _____
Date_____