Central Arkansas Surgical Center

Pre-Admission Information

(To be filled out with each visit)

To be filled out by all patients

What is the purpose of today's visit_____

Are you a diabetic? Yes / No If yes, did you check your blood sugar today? Yes / No Results_____Time_____

When was the last time you had anything to eat or drink?_____(this includes gum, mints, tobacco products)

Who will be taking you home today? (please list name) _____ Phone number_____

Your pain level today (use 0-10 pain scale)_____ 0= No pain 10= Worst imaginable pain

In order to protect your health information please provide the following:

* A follow up call will be placed to you on the next business day following your visit with us. Please provide us with a phone number we may call._____Home/Cell/Work.
* May we leave a message at the above listed number? YES / NO
* May we speak with anyone who answers the phone? YES / NO
* May we inform other of your presence in our Center? YES / NO
* Do you have any health information that you would like to be kept confidential from any person or persons? If so, please specifically describe the information and person or persons:_____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

Females only: Are you pregnant or is there any chance you may be pregnant? YES / NO

Date of last menstrual period_____ Have you had a hysterectomy or tubal ligation YES / NO

FOR RETURNING PATIENTS ONLY:

Has there been any change in you medical history since your last visit? (example hospitalizations, new medications,
new allergies, new diagnoses/ illness) Please explain_____

Please add the following medication(s) to my medication and allergy sheet_____

Please remove the following medications from my medication and allergy sheet_____

Patient or Authorized Person Signature_____

Date_____

Relationship to patient if patient unable to sign_____