RIDGEDALE SURGERY CENTER

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T: 973-605-5151 / F: 800-605-4456
www.ridgedalesurgerycenter.com

PATIENT QUESTIONNAIRE (PLEASE PRINT)

Dear Patient,

Please complete the following questionnaire and **fax or mail to Ridgedale Surgery Center, prior to your procedure date (see below).** Please include a day time phone number where you can be reached the day before your procedure. You will receive a phone call giving instructions as to your arrival time and the time of your procedure. If you can not be reached, please call the surgery center after 11:00 am the day before your procedure.

Patient Name: ______________________ DOB: ______________ SS # ______________

Surgeon: ______________ Procedure: ______________ Procedure Date: ______________

Number I can be reached the day before my procedure: ______________________

Emergency Contact: ______________ Phone # ______________ Relationship to Patient: ____________

Employer (Name, Address, Phone #): ______________________________________

____

If we are unavailable to reach you, can we leave a message on your answering machine: ☐ Yes ☐ No

MEDICAL HISTORY

Brief History of Current Illness: ______________________________________

Please circle any of the following which apply to you:

High blood pressure	Angina/chest pain	Heart attack	Pacemaker/Implanted Defibrillator
Valve Prolapse/Prosthesis	Heart Failure/CHF	Irregular heart beat	Diabetes - insulin or oral meds
High Cholesterol	Asthma	Emphysema/COPD	Cough/Shortness of Breath
Chronic Bronchitis	Sleep Apnea	Seizure disorder	Neurologic disorder
Stroke/TIA	Hiatal Hernia/Reflux	Ulcers/Colitis	Kidney Disease
Hepatitis/Liver Disorder	Thyroid disorder	Muscle/Joint disorder	Cancer: ______________
Genitourinary/Incontinence	Clotting disorder	Anemia	Other: ______________

Please list all previous surgeries:
____
____
____

List any Allergies:
____
____
____

Social History:
Do you smoke? ☐ no ☐ yes
Do you drink alcohol? ☐ no ☐ yes
if yes, how much? ____________

Medications: Please list or attach a list: **On the day of your procedure you will need to complete a Medication History Form for medication you are taking related to your procedure/body system, with exact dosages This form is also available from your physician or from our website prior to the date of your procedure.**

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

Do you take aspirin or blood thinners? ☐ no ☐ yes If yes, when was last dose? ____________

Have you or any blood relatives had any adverse reactions to anesthesia? ☐ no ☐ yes If yes, please explain______________

Patient Signature: ______________________________ **Date**: ______________________

INSURANCE INFORMATION (please print clearly and fill out in completion)

Primary Insurance______________________ Secondary Insurance ______________________

ID Number______________________ ID Number ______________________

Group Number______________________ Group # ______________________

Subscriber______________________ Subscriber ______________________

Birth date____________ SS#____________ Birth Date ____________ SS# ____________

Employer:______________________ Relationship to patient: ☐Self ☐Spouse ☐Parent ☐Other____________

IF YOUR INSURANCE CHANGES BETWEEN SCHEDULING AND THE DATE OF PROCEDURE, YOU MUST NOTIFY US AS SOON AS POSSIBLE SO WE MAY OBTAIN THE PROPER REFERRALS AND PRECERTIFICATION NECESSARY.

Name of person completing this form ______________________________

Relationship to patient: ☐Self ☐Other______________ If Other, do you have Power of Attorney: ☐ Yes ☐ No ☐ N/A