Carol A Hollan M.D.
9850 Genesee Ave. #380 La Jolla CA 92037
PATIENT INFORMATION

Name: ______________________ ______________________ ______ Date: __________
(Last) (First) (M.I.)

Address: ________________________________ City: __________ State: ____ Zip: ________

May we call you at home: yes no ok to leave a message to call back

Home #: ( )______________ Work #: ( )______________ Cell #: ( )______________

E-mail: ______________________________________

S.S. #______________ Birth date: __________ Age: ______ Marital Status: S M D W (please circle)

Employer: ______________ Position: ______________ May we call you at work: yes no

Emergency Contact: ______________________ Relationship: ______________________

Home #: ( )______________ Work #: ( )______________

Are you allergic to any medications? yes no If yes, please list: ______________________

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♦♦

What would you like to discuss with the doctor today? ______________________________

____

How did you hear about Dr. Hollan? ______________________ Relationship: ______________

♦♦

Primary Physician: ______________________ Phone #: ( )__________ Fax #: ( )__________

Pharmacy Name: ______________________ Phone #: ( )__________ Fax #: ( )__________

♦♦

Responsible Party : ______________________ S.S.#:______________ D.O.B.:________
(if other than self)
Relationship: ______________ Your Insurance ID #:______________ Group#:__________

Insurance Name:______________________ Phone #: ( )__________ PPO POS Other (please circle)

Insurance Address:____

I understand Dr. Hollan is not accepting assignment with my insurance. I authorize Dr Hollan to release any information necessary to process claims on my behalf. I am aware that I am responsible and will pay for all charges prior to services provided. **Consent of treatment:** I authorize Dr. Hollan to administer medical treatment appropriate to my medical condition.

♦♦

Patient/Responsible Party Signature: ______________________________ Date: __________
Annual update: Initial if no changes __________

NAME:________________________ AGE:_____ DATE:__________

Do you currently take:

Aspirin (Excedrin, Anacin, Bufferin, Alka Seltzer)	Yes	No
Anticoagulants (blood thinning medication)	Yes	No
Sedatives (sleeping medication, tranquilizers)	Yes	No
Heart Medication or high blood pressure medications	Yes	No
Diuretic (water pills)	Yes	No
Steroids (prednisone)	Yes	No
Herbal Remedies	Yes	No

Allergies:

Antibiotics	Yes	No
Penicillin	Yes	No
Mycins (Erythromycin)	Yes	No
Sulfa	Yes	No
Iodine	Yes	No
Tape	Yes	No
Foods	Yes	No
Other, please identify	Yes	No

Have you ever had:

Diabetes	Yes	No
High Blood Pressure	Yes	No
Blood Transfusion	Yes	No
HIV Test, Result____	Yes	No
Radiation Therapy	Yes	No
Chemotherapy	Yes	No
Pneumonia	Yes	No
Hepatitis	Yes	No
Rheumatic Fever	Yes	No

Current Medications: ______________________________

____

Surgeries/Hospitalizations: ____________ **Year:** ____________

____________ ____________

____________ ____________

Pregnancies ________

No. of Children ________

Caesarean Sections ________ Weight ________ Height ________

Do you smoke? Yes No _____ packs per day Quit _________(year)

Do you drink alcohol? Yes No _____ glasses per week

Any family history of diabetes, high blood pressure, heart disease, cancer? (circle all that apply)

Explain: ______________________________

____

Systems:

Have you or anyone in your family had a bleeding problem?	Yes	No
Have you ever had a prolonged bleeding from nose bleeds, tooth extractions, cuts or surgery?	Yes	No
Have you recently had chills, cold or flu?	Yes	No
Have you been told you were anemic?	Yes	No
Have you ever had or currently have an eating disorder?	Yes	No
Do you have problems with headaches, migraines?	Yes	No
Have you ever had a seizure, or epilepsy?	Yes	No
Do you have problems with any of the following: (circle all that apply):		
*Sinusitis or ear ringing	Yes	No
*Asthma, shortness of breath, cough, bronchitis	Yes	No
*Chest pain, palpitations, ankle swelling, dizziness	Yes	No
*Nausea, vomiting, diarrhea, constipation, blood in the stool, tarry stool Vomiting blood, hemorrhoids, ulcers, hiatal hernia	Yes	No
*Urinating with difficulty, pain, blood, frequency, kidney stones, infections	Yes	No
*Back or neck problems, arthritis	Yes	No
*Muscle cramps or spasms	Yes	No
*Nervousness or depression	Yes	No
*Breast lumps, pain or nipple discharge	Yes	No
*Are you pregnant or is there a possibility that you could be pregnant?	Yes	No

What number can we reach you at after surgery:____________________

The American Association for Accreditation of
Ambulatory Surgery Facilities, Inc.
A Patient's Bill of Rights

The accredited ambulatory surgery facility presents a Patient's Bill of Rights with the expectations that observance of these rights will contribute to more effective patient care and greater satisfaction of the patient, his/her physician, and the group organization. It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes a new dimension when care is rendered within an organizational structure. Legal precedent has established that the facility itself also has a responsibility to the patient. It is in recognition of these factors that these rights are affirmed.

1. The **patient** has the right to considerate and respectful care.
2. The **patient** has the right to obtain from his/her physician complete current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his/her behalf. He/she has the right to know, by name, the physician responsible for coordinating his/her care.
3. The **patient** has the right to receive from his/her physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure an/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternative, the patient has the right to know the name of the person responsible for the procedures and/or treatment.
4. The **patient** has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his/her action.
5. The **patient** has the right to every consideration of his/her privacy concerning his/her medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his/her care must have permission of the patient to be present.
6. The **patient** has the right to expect that all communications and records pertaining to his/her care should be treated as confidential.
7. The patient has the right to expect that within its capacity, this accredited ambulatory surgery facility must provide evaluation, service and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he/she has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.
8. The **patient** has the right to obtain information as to any relationship of this facility to other health care and educational institutions insofar as his/her care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him/her.
9. The **patient** has the right to be advised if this accredited ambulatory surgery facility proposes to engage in or perform human experimentation affecting his/her care of treatment. The patient has the right to refuse to participate in such research projects.
10. The **patient** has the right to expect reasonable continuity of care. He/she has the right to know in advance what appointment times and physicians are available and where. The patient has the right to expect that this facility will provide a mechanism whereby he/she is informed by his physician of the patient's continuing health care requirements following discharge.
11. The **patient** has the right to examine and receive an explanation of his/her bill regardless of the source of payment.
12. The **patient** has the right to know what facility rules and regulations apply to his/her conduct as a patient.

No catalog or rights can guarantee for the patient the kind of treatment he/she had a right to expect. This facility has many functions to perform, including the prevention and treatment of disease, the education of both health professionals and patient, and the conduct of clinical research. All these activities must be conducted with an overriding concern for the patient, and above all, the recognition of his/her dignity as a human being. Success in achieving this recognition assures success in the defense of the rights of the patient.

PATIENT RESPONSIBILITIES

It is the **patient's** responsibility to fully participate in decisions involving his/her own health care and to accept the consequences of these decisions if complications occur.

The **patient** is expected to follow up on his/her doctor/s instructions, take medication when prescribed, and ask questions concerning his/her own health care that he/she feels is necessary.

PATIENT SIGNATURE:____ DATE:________________

SCHEDULING PROCESS

The scheduling process can take place, after both you and the doctor have met and have decided that you are a good candidate for the surgery. This written process is to help you understand how we schedule surgeries.

HOLDING A DATE: A "surgical date" may be held for two weeks. Once you have made the final decision to schedule you will speak with the surgery scheduler to confirm that surgical date. If we do not hear from you by the end of the two-week period, and cannot contact you, we will release the date you have held. Our surgery scheduler will make three earnest attempts to contact you before releasing the date..

SCHEDULING A DATE: Surgeries are scheduled throughout the week. Surgeries are scheduled in our accredited facility, as well as other outpatient facilities and hospitals. There are many factors that play a major role in where the surgery will be scheduled. Once it has been determined where the surgery will take place, we will choose a date together. At this time, your pre-operative and post-operative appointments will also be scheduled. You will be mailed or given a list of medications to discontinue 14 days prior to surgery along with an informative sheet of what to plan for two-weeks before, the day before, the morning of surgery, and your post-operative period.

NON-REFUNDABLE DEPOSIT & PAYMENT OF SURGICAL FEES: Upon confirmation of your surgical date our office requires a non-refundable deposit of $500.00. All surgical fees are due at the time of your pre-operative visit. If you must postpone your surgery and you give 10 business days notice, you may reschedule your surgery without loss of your deposit. If your surgery is cancelled 10 business days prior to surgery for a non-medical reason, you will be charged 50% of the total estimate. If surgery must be cancelled for medical reasons, 10% of your total fee will be charged as a processing fee.

I, ______________________________ am aware that by my signing this form, I am acknowledging
Patient name – please print
that I have read and understand Dr. Hollan's Scheduling Policy.

Patient Signature: ___________________________ **Date:** __________

Witness Signature: __________________________ **Date:** __________

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