Grants Pass
SURGERY
CENTER

Return your completed packet to the Surgery Center As Soon As Possible.

Please bring your insurance cards and picture I.D. to ensure proper billing.

Thank you!

Grants Pass
SURGERY CENTER

541-472-4880 Phone
541-472-4899 Fax
1601 NW Hawthorne Ave.
Grants Pass, Oregon 97526
gpsurgerycenter.com

PATIENT COPY

GETTING READY FOR YOUR SURGERY

Please read the included registration packet carefully. The last two pages must be completed and returned to the Grants Pass Surgery Center as soon as possible. Please make an effort to return the form **no later than three days prior to your procedure.**

PRE-REGISTRATION HOURS ARE
6:30 AM – 4:00 PM, MONDAY – FRIDAY

Grants Pass Surgery Center
1601 NW Hawthorne Ave.
Grants Pass, Oregon 97526

One of our experienced pre-op nurses will call one day prior to your surgery to obtain critical information about your health history and provide instructions tailored to your surgery.

YOUR PROCEDURE IS CURRENTLY SCHEDULED FOR:

Mon Tues Wed Thurs Fri

Date _____

(Arrival times are given and finalized by a call from the Surgery Center one business day before your surgery.)

IMPORTANT THINGS TO REMEMBER

- Because we care, you are required to have a driver after your procedure. Failure to do so may result in the rescheduling of your procedure.
- Each physician has specific instruction for you to follow. Always follow these instructions.
- **DO NOT Eat Or Drink Anything After Midnight The Night Before Your Surgery** (NOT EVEN WATER, CHEWING GUM, or CANDY).
- Please bring your drivers license or student ID, and your current insurance cards with you.
- If you have general questions, please call 541-472-4880.
- If you have patient billing and insurance questions, please call 1-866-760-0123.

Grants Pass Surgery Center

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NOTICE OF PHYSICIAN OWNERSHIP AND FINANCIAL INTEREST

Please call 541-472-4880 for verbal list of physician owners.

Alexandridis, Alexis MD
1600 NE 6th Street, Ste. N
Grants Pass, Oregon 97526

Battey, Richard MD
1075 SW Grandview Ave., Ste. 200
Grants Pass, Oregon 97527

Bents, Robert MD
702 SW Ramsey Ave., Ste. 112
Grants Pass, Oregon 97527

Castle, John DPM
1227 NE 7th Street
Grants Pass, Oregon 97526

Cohen, Felicia MD
1075 SW Grandview Ave., Ste. 200
Grants Pass, Oregon 97527

Deatherage, Mark MD
1600 NE 6th Street, Ste. N
Grants Pass, Oregon 97526

Fear, Daniel MD
1600 NW 6th Street, Ste. A
Grants Pass, Oregon 97526

Froehlich, Monika DPM
495 SW Ramsey Ave.
Grants Pass, Oregon 97527

Martin, Aaron DO
537 Union Ave., Ste. 205
Grants Pass, Oregon 97527

Mateja, Brian DO
509 E Main St.
Rogue River, Oregon 97537

Perry, Bruce MD
1619 NW Hawthorne, Ste. 102
Grants Pass, Oregon 97526

Pitzak, Andrew DO
495 SW Ramsey Ave.
Grants Pass, Oregon 97527

Schulte, Brett MD
1600 NW 6th Street, Ste. N
Grants Pass, Oregon 97526

Simchuk, Mark MD
1619 NW Hawthorne, Ste. 106
Grants Pass, Oregon 97526

Van Horne, James MD
702 SW Ramsey Ave., Ste. 112
Grants Pass, Oregon 97527

Waschak, John DDS
560 NE E Street
Grants Pass, Oregon 97526

OHRP STATEMENT

The office for Oregon Health Policy and Research (OHRP) requires all licensed free-standing ambulatory surgery centers to collect and report the following race and ethnicity information on all patients:

Note: The information reported will be confidential, Please designate a race and ethnic category on the Pre-registration form at the front of the packet.

Race categories are:

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Pacific Islander
- White
- Patient refused

Ethnic categories are:

- Hispanic or Latino
- Non Hispanic or Latino
- Patient refused
- Unknown

Questions and/or concerns can be addressed by the office of Oregon Health Policy & Research (OHRP) by calling (503) 373-2287.

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PATIENT COPY

ACKNOWLEDGMENT AND CONSENT

I understand that Grants Pass Surgery Center (referred to below as GPSC) will use and disclose "Protected Health Information" or "PHI" about me.

I understand that my PHI may include information both created and received by GPSC and may be in the form of written or electronic records. I understand that my PHI may include information about my health history, health status, symptoms, examinations, test results, diagnosis, treatments, procedures, prescriptions, related billing activities and similar types of health-related information.

I understand and agree that GPSC may use and disclose my PHI in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate amount, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care;
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have a right to receive and review a written description of how GPSC will handle my PHI. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of PHI and the information practices followed by the employees, staff, and other office personnel of GPSC, and my rights regarding my PHI.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of the current Notice of Privacy Practices. I also understand that a copy or a summary of the current Notice of Privacy Practices in effect will be posted in waiting and reception area and is available from our front office staff.

I understand that I have a right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that GPSC is not required by law to agree to such requests.

By signing the Acknowledgment and Consent section of the Patient Registration Signature Form, I agree that I have received and understand the information above and that I have received a copy of the Notice of Privacy Practices.

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PATIENT COPY

PATIENT'S RIGHTS AND RESPONSIBILITIES

1. The patient will receive the care necessary to help regain or maintain maximum state of health and, if necessary, cope with death.
2. The facility personnel who care for the patient will be qualified through education and experience to perform the services for which they are responsible. The patient has the right to identify the professional status of all individuals providing services to him/her.
3. The patient will be treated with consideration, respect, and full recognition of individuality, including privacy in treatment and in care.
4. The patient will be provided (to the extent known) by the physician, complete information regarding diagnosis, treatment and the prognosis as well as the possible risks and side effects associated with treatment. If medically inadvisable to disclose to the patient such information, the information is given to a person designated by the patient or to a legally authorized individual. Within the limits of the facility service policy, the patient and family will be instructed in appropriate care techniques.
5. The patient or responsible person will be fully informed of services available in the facility, provisions for after-hours and emergency care, and related fees for services rendered.
6. The patient will be a participant in decisions regarding the intensity and scope of treatment. Circumstances under which the patient may be unable to participate in his/her plan of care will be recognized. In these situations, the patient's rights will be exercised by the patient's designated representative or other legally designated person.
7. The patient will have the right to accept medical care or refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal. The patient also has the responsibility for his/her actions should he/she refuse treatment and does not follow the physician's or the Surgery Center's instructions and will be requested to sign a release of responsibility form. If refused, a registered letter will be sent.
8. Plans will be made with the patient and family so that continuing services will be available to the patient throughout the period of need. The plans will be timely and involve the use of all appropriate personnel and community resources.
9. Facility personnel will keep adequate records and will treat with confidence all personal matters that relate to the patient.
10. The patient will have the right to approve or refuse the release of medical records to any individual outside the facility, except in the case of transfer to another health facility, or as required by law or third party payment contract.
11. The patient has the right to be informed of any human experimentation or other research l educational projects affecting his or her care or treatment and to refuse participation in such experimentation or research.

12 The patient will be free from all forms of abuse harassment. The Surgery Center will provide for and welcome the expression of grievances or complaints and suggestions by the patient at all times.

13 The patient will have the right to change primary or specialty physicians or dentists if other qualified physicians or dentists are available.

14 The patient will have the right to have an advance directive, such as a living will or health-care proxy. These documents express the patient's choices about future care or name someone to decide if the patient cannot speak for himself or herself. The patient who has an advance directive should provide a copy to the Grants Pass Surgery Center and to their physician for their wishes to be made, known and honored in the event of a transfer to the hospital.

15 The patient will have a right to be fully informed before any transfer to another facility or organization if appropriate for optimum patient care.

16 The patient will be responsible for observing prescribed rules of the Surgery Center during his or her stay and treatment. The patient forfeits the right to care at the Grants Pass Surgery Center if printed instructions are not followed.

17 The patient will be responsible for promptly fulfilling his or her financial obligations to the Surgery Center.

18 The patient will be responsible for being considerate of other patients and personnel and for assisting in the control of noise, smoking, and the number of visitors.

19 The patient will be responsible for reporting whether he/she clearly understands the planned course of treatment and what is expected.

20 The patient will be responsible for keeping appointments and, when unable to do so for any reason, must notify the Surgery Center and physician.

21 Patient care rendered will reflect consideration for the patient as an individual with personal value and belief systems that affect his or her attitude toward and response for the care provided by the Grants Pass Surgery Center. Patients will be allowed to express those spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of medical therapy for the patient.

22 The patient or the patient's designated representative may participate in the consideration of ethical issues that arise in the care of the patient.

23 All patients will receive appropriate assessment and management of pain through continuum of care.

24 The patient is encouraged to report concerns about safety throughout or after their course of care.

Our patient advocate will answer written complaints and or handle verbal complaints. There is to be no fear of reprisal, discrimination or impact on the quality of care received.

If we are unable to resolve an issue you may contact:

Oregon Health Care Licensure and Certification office at: 971-673-0540. http://www.oregon.gov/DHS/ph/hclc

Medicare beneficiary: 1-800-633-4227. http://www.oregon.gov/DHS/ph/hclc

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PATIENT COPY

NONDISCRIMINATION NOTICE

Grants Pass Surgery Center, complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Grants Pass Surgery Center provides:

- free aids and services to people with disabilities to help them communicate effectively with us. These aids and services include:
  * qualified sign language interpreters
  * written information in other formats (large print, audio, accessible electronic formats, other formats)
- free language services to people whose primary language is not English, such as:
  * qualified interpreters
  * materials written in other languages

If you need these services, contact Grants Pass Surgery Center at 541-472-4880. If you believe that Grants Pass Surgery Center has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mailing or faxing to:

Mr Steven M. Loftesnes, CEO / Administrator
1601 NW Hawthorne Ave.
Grants Pass, OR 97526

Phone: 541-472-4880
Fax: 541-472-4899
Email: sloftesnes@gpsurgerycenter.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Mr Steven M. Loftesnes, CEO / Administrator, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Atención: Si habla español, hay disponibles servicios de ayuda con el idioma sin costo alguno para usted. Llame al 1-866-605-3229 (TTY:711).

Attention : Si vous parlez espagnol, les services sont disponibles pour aider à la langue à aucun coût à vous. Composez le 1-866-605-3229 (ATS : 711).

Achtung: Wenn Sie Spanisch sprechen oder Dienste zur Verfügung stehen, um mit der Sprache ohne Kosten für Sie. Unter der Nummer 1-866-605-3229 (TTY:711).

Attenzione: se si parla spagnolo i servizi sono disponibili per aiutare con la lingua senza alcun costo per voi. Chiamare il numero 1-866-605-3229 (TTY:711).

Obs: Hvis du snakker spansk tjenester er tilgjengelig for å hjelpe med språk uten kostnader for deg. Ring 1-866-605-3229 (TTY:711).

Obs: Hvis du taler spansk, har mulighed for hjælp med sprog uden omkostninger for dig. Call 1-866-605-3229 (TTY:711).

Tähelepanu: kui räägid hispaania teenused on saadaval aitama, keel on teie jaoks tasuta. Helista 1-866-605-3229 (TTY:711).

Figyelem: Ha beszélsz spanyolul szolgáltatások érhetők el, melyek a nyelv. 1-866-605-3229 (TTY:711).

Atenção: se você fala espanhol os serviços estão disponíveis para ajudar com a língua sem nenhum custo para você. 1-866-605-3229 (TTY:711).

Atenție: Dacă vorbeşti spaniola de servicii sunt disponibile pentru a vă ajuta cu limba de cost. Apelați 1-866-605-3229 (TTY:711).

Pažnja: Ukoliko vam govore španski servisa za pomoć sa jezik bez kompenzacije. Pozovite 1-866-605-3229 (TTY:711).

Pozor: Ak budete hovoriť po španielsky služby nie sú k dispozícii, aby sme vám pomohli s jazykom bezplatne. Volajte 1-866-605-3229 (TTY:711).

Obs! Om du pratar spanska tjänster är tillgängliga för att hjälpa till med språket hos nrkostnad till dig. Ring 1-866-605-3229 (TTY:711).

Perhatian: Jika anda berbicara bahasa Spanyol layanan yang tersedia untuk membantu dengan bahasa di tanpa biaya untuk anda. 1-866-605-3229 panggilan (711):TTY.

Uwaga: Jeżeli rozmawiasz hiszpański usługi są dostępne, aby pomóc z językiem bez żadnych kosztów. Zadzwoń pod numer 1-866-605-3229 (TTY:711).

Grants Pass Surgery Center

541-472-4880 Phone
541-472-4899 Fax
1601 NW Hawthorne Ave.
Grants Pass, Oregon 97526
gpsurgerycenter.com

PATIENT COPY

NOTICE OF POLICY REGARDING ADVANCED DIRECTIVES

Grants Pass Surgery Center requires the following notice be signed by each patient prior to the scheduled procedure, in order to be in compliance with the Patient Self-Determination Act (PSDA) and state law and rules regarding Advanced Directives.

Advanced Directives are statements that indicate the type of medical treatment wanted or not wanted in the event an individual is unable to make those determinations and who is authorized to make those decisions. The Advanced Directives are made and witnessed prior to serious illness or injury.

There are many types of Advanced Directives but the two most common forms are:

- **Living Wills** - These generally state the type of medical care an individual wants or does not want if he/she becomes unable to make his/her decisions.
- **Durable Power of Attorney for Health Care** - This is a signed, dated and witnessed paper naming another person as an individual's agent or proxy to make medical decisions.

In an ambulatory care setting, if a patient should suffer a cardiac or respiratory arrest or other life-threatening situation, this signed consent implies consent for resuscitation and transfer to a higher level of care. Therefore, in accordance with federal and state law, the facility is notifying you it will not honor previously signed Advanced Directives for any patient. If you disagree, you must address this issue with your physician prior to signing this form.

I understand that I am not required to have an Advanced Directive in order to receive medical treatment in this heath care facility.

By signing the Advanced Directives section of the Patient Registration Signature Form, I agree that I have received and understand the information above and that I have received a copy of the Notice of Policy Regarding Advanced Directives.

Grants Pass
SURGERY CENTER

541-472-4880 Phone
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PATIENT COPY

ENDOSCOPY–COLONOSCOPY PRE-REGISTRATION INFORMATION

One of our highly skilled nurses will contact you by telephone a minimum of 1 day in advance of your scheduled procedure to cover you pertinent medical history. Due to our continually changing schedule, your time may change. You will be contacted by a member of our experienced front office staff 1 business day prior to your procedure to inform you of your arrival time. Typically we will have you arrive approximately 1 hour prior to your scheduled surgery time. If you do not receive a call 1 business day prior to your procedure, please call (541) 472-4880, 9am to 5pm.

Please follow the directions below:

1. Do not eat or drink anything (including water) after midnight unless otherwise instructed. You may brush your teeth or rinse your mouth, please don't swallow.
2. If you are having a colonoscopy it is very important that you follow the diet and instructions given to you by your doctor. Please contact the Surgery Center or your doctor if you have not received instructions for taking the endoscopy colon prep.
3. No smoking the morning of surgery.
4. No alcohol the night prior to surgery (there is a possibility of alcohol reacting with the anesthetic agents).
5. Regular Medications: Take your medication according to your physician's instructions. If you have not received any instructions please take all medications except insulin, hypo-glycemics and diuretics. If you take Coumadin or aspirin please contact your physician.
6. Bathe in the morning before coming to the surgery center, wear something comfortable. You will be asked to change into a patient gown.
7. If you wear glasses, please bring an eyeglass case.
8. Leave all valuables, including money and jewelry at home.

After your procedure:

1. You will be taken to the recovery room and a nurse will watch you carefully and monitor your blood pressure and heart rate.
2. You will receive written instructions to follow.
3. A responsible adult must drive you home. Failure to have a ride may result in the rescheduling of your procedure.

We have a lobby with coffee and tea for your friend or relative to wait. If your family or driver must leave for a short time, please check with the nurse for a time to return. We want your experience with us to be pleasant.

Grants Pass Surgery Center

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Grants Pass, Oregon 97526
gpsurgerycenter.com

PATIENT REGISTRATION

PATIENT INFORMATION

Last name _____ First _____ Middle _____
Date of birth _____ Social Security # _____ ☐ Male ☐ Female
Cell phone _____ (☐ preferred?) Home phone _____ (☐ preferred?)
Mailing address _____ City _____ State _____ Zip _____
Home address _____ City _____ State _____ Zip _____
Email address _____
Employer _____ Student: ☐ Full-time ☐ Part-time
PCP name _____ Surgeon _____
Parent/Legal Guardian _____

SURGERY INFORMATION

Procedure(s) you are having _____

_____

Surgery/procedure date _____

DISCLOSURE OF HEALTH INFORMATION With whom may we discuss your care?

Name	Relationship	Conditions of access *All*	*Health only*	*Ride only*	Name	Relationship	Conditions of access *All*	*Health only*	*Ride only*
		☐	☐	☐			☐	☐	☐
		☐	☐	☐			☐	☐	☐

OHRP INFORMATION (required by the State)

Race ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Prefer not to answer

Ethnicity ☐ Hispanic or Latino ☐ Non-hispanic or Latino ☐ Unknown ☐ Prefer not to answer

RESPONSIBLE PARTY

Last name _____ First _____ Date of birth _____
Mailing address _____ City _____ State _____ Zip _____
Home address _____ City _____ State _____ Zip _____
Home phone _____ Cell phone _____ Social Security # _____

PRIMARY INSURANCE

Ins. Company _____
Address _____
Benefit phone _____
Subscriber name _____
Subscriber SS# _____
Subscriber DOB _____
Policy # _____
Group # _____

SECONDARY INSURANCE

Ins. Company _____
Address _____
Benefit phone _____
Subscriber name _____
Subscriber SS# _____
Subscriber DOB _____
Policy # _____
Group # _____

W-C / INJURY INSURANCE

Ins. Company _____
Address _____
Benefit phone _____
Subscriber name _____
Subscriber SS# _____
Subscriber DOB _____
Policy # _____
Group # _____

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PATIENT REGISTRATION SIGNATURES

Patient's last name _____ First _____ Middle _____

Date of birth _____ Social Security # _____

STANDARDS OF PATIENT RIGHTS AND RESPONSIBILITIES

I have been offered the opportunity, both written and verbally, to understand the Standards of Patient Rights and Responsibilities. Patient Initial _____

ACKNOWLEDGMENT AND CONSENT

I agree that I have received and understand the Grants Pass Surgery Center's Acknowledgment and Consent disclosure and that I have been offered a copy of the Notice of Privacy Practices. Patient Initial _____

PERMISSION TO DISCLOSE HEALTH INFORMATION

I hereby grant Grants Pass Surgery Center permission to discuss my medical care with persons I have listed on the Patient Registration form. The individuals listed have my permission to share my health information within the confines of the conditions noted. Patient Initial _____

OHRP STATEMENT

I understand that the Oregon Health Policy and Research office requires all licensed free-standing ambulatory surgery centers to collect and report race and ethnicity information on all patients. Additionally, I understand that I can decline to provide this information. Patient Initial _____

NOTICE OF PHYSICIAN OWNERSHIP

If my physician's name appears in the provided list (see notice attached), I understand that he or she has a financial interest in Grants Pass Surgery Center. Initialing here verifies that I have been offered a written and verbal list of physician owners. Patient Initial _____

POLICY REGARDING ADVANCE DIRECTIVES

This signed form implies consent for resuscitation and transfer to a higher level of care. Therefore, in accordance with federal and state law, the facility is notifying you it will not honor previously signed Advance Directives for any patient. If you disagree, you must address this issue with your physician prior to signing this form. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this healthcare facility. Patient Initial _____

- ☐ I have executed an Advance Directive and have been asked to provide a copy to Grants Pass Surgery Center.
- ☐ I have not executed an Advance Directive.
- ☐ I understand that I am not required to have an Advance Directive in order to receive medical treatment in this healthcare facility.

PATIENT SIGNATURE _____ WITNESS TO SIGNATURE _____

PARENT/LEGAL GUARDIAN SIGNATURE *(if patient is under 14 years of age or otherwise unable)* _____ DATE _____

Grants Pass SURGERY CENTER

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PRE-SURGERY EVALUATION

Last name _____ First _____ Middle _____ Date of birth _____

ARE YOU ALLERGIC TO ANY MEDICINES?

Medicine	Reaction	Medicine	Reaction

Please indicate whether you have or have not had the following conditions:

GENERAL

Weight? _____ Height? _____

Are you pregnant?	☐ Y	☐ N
Are you taking blood thinners or aspirin?	☐ Y	☐ N

HEART

Blocked artery: heart / neck / limb *(circle one)*	☐ Y	☐ N
Heart attack	☐ Y	☐ N
Chest pain/Angina	☐ Y	☐ N
Heart murmur	☐ Y	☐ N
Congestive heart failure	☐ Y	☐ N
Irregular heartbeat	☐ Y	☐ N
Coronary artery disease	☐ Y	☐ N
High blood pressure	☐ Y	☐ N
Heart valve disease	☐ Y	☐ N
Rheumatic fever	☐ Y	☐ N
Heart surgery (When? _____)	☐ Y	☐ N
Pacemaker or implanted defibrillator	☐ Y	☐ N

LUNG

Asthma	☐ Y	☐ N
Emphysema	☐ Y	☐ N
Bronchitis	☐ Y	☐ N
TB	☐ Y	☐ N
Shortness of breath? At rest / with activity *(circle one)*	☐ Y	☐ N
Pneumonia in the past 6 months	☐ Y	☐ N
Recent respiratory infection	☐ Y	☐ N
Chronic or current cough	☐ Y	☐ N
Do you use oxygen at home?	☐ Y	☐ N
Do you use an inhaler/breathing treatment?	☐ Y	☐ N

OTHER CONDITIONS

Hiatal hernia	☐ Y	☐ N
Gastric reflux / Heartburn *(circle one)*	☐ Y	☐ N
Hepatitis A / B / C *(circle one)*	☐ Y	☐ N
Jaundice	☐ Y	☐ N
Cirrhosis	☐ Y	☐ N
Kidney problems or stones	☐ Y	☐ N
Thyroid disease	☐ Y	☐ N
Diabetes Controlled by: diet / oral agent / Insulin *(circle one)*	☐ Y	☐ N
Steroids or cortisone in the past 6 months	☐ Y	☐ N
Bad reaction to anesthesia	☐ Y	☐ N
Seizures	☐ Y	☐ N
Stroke / TIA (When? _____)	☐ Y	☐ N
Paralysis / numbness / weakness *(circle one)* Where? _____	☐ Y	☐ N
Arthritis	☐ Y	☐ N
Cancer Radiation / chemotherapy? *(circle one)*	☐ Y	☐ N
Bleeding tendency	☐ Y	☐ N
Senile dementia / Alzheimer's *(circle one)*	☐ Y	☐ N
Hard of hearing / Deaf *(circle one)*	☐ Y	☐ N
Blindness or injury to eye – L / R *(circle one)*	☐ Y	☐ N
Anxiety/panic attacks/claustrophobia *(circle one)*	☐ Y	☐ N

DO YOU:

Drink alcohol? (How much? _____)	☐ Y	☐ N
Smoke? (How much? _____)	☐ Y	☐ N
How long have you smoked? _____		
If you quit, when? _____		
Use street drugs? Which? _____	☐ Y	☐ N

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MEDICATION / HOSPITALIZATION SUMMARY

Last name _____ First _____ Middle ____ Date of birth _____

You are scheduled for your surgery at Grants Pass Surgery Center. Please accurately complete this form and bring it with you to the Surgery Center when you pre-register. (It is not necessary to duplicate medications, allergies, or previous surgeries on the pink pre-surgery evaluation record.)

CURRENT MEDICATIONS **Prescriptions, herbal supplements, and over-the-counter medications.**

When listing your medications, be very specific. Please read the bottle, spell the name of the medication correctly, list the dosage as indicated on the bottle. And don't forget to list when you take the medication (morning or evening).

Name	Dosage	Frequency	Time of day

POST-OPERATIVE MEDICATIONS

Name	Dosage	Frequency	Time of day

PREVIOUS HOSPITALIZATIONS AND/OR SURGERIES

Type	Date (month and year)	Type	Date (month and year)