Grants Pass
SURGERY
CENTER

Please bring your packet on the date of your COVID test and leave in our drop box located on the outside of our building. We are not doing pre-registration in our lobby due to COVID.

Pre-registration can also be completed online at:
www.gpsurgerycenter.com

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

Thank you!

Grants Pass
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Ph. 541.472.4880
Fax. 541.472.4899
1601 N.W. Hawthorne Ave. • Grants Pass, Oregon 97526 • www.gpsurgerycenter.com

Getting Ready For Your Endoscopy / Colonoscopy

Please read the included registration packet carefully. The last three pages must be completed and returned to the Grants Pass Surgery Center as soon as possible. **Please note**; when returning your packet, leave it in our drop box located on the outside of the building due to COVID safety precautions. Please make an effort to return the form **no later than three business days prior to your procedure.**

PRE-REGISTRATION HOURS ARE FROM

6:30 AM - 4:00 PM, MONDAY - FRIDAY

Grants Pass Surgery Center

1601 NW Hawthorne Ave., Grants Pass, OR 97526

One of our experienced pre-op nurses will call 4-5 business days prior to your procedure to obtain critical information about your health history and provide instructions tailored to your procedure.

Your procedure is scheduled for:

Mon Tues Wed Thurs Fri

DATE: _____ TIME: _____

(Arrival times are given and finalized by a call from the Surgery Center two business days before your procedure.)

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.
- **We are not allowing any family members to come into our facility unless patient is a minor or needs assistance.**
- 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 Procedure, Unless your Prep instructions from the physician's office directs otherwise. (NOT EVEN WATER, CHEWING GUM, or CANDY).**
- Please bring your driver's license or student ID, and your current insurance cards with you.
- Anesthesia and physician fees are separate than our fees. Please contact your surgeon for physician fees and Rogue Anesthesia at 888-278-4119 for their fees.
- If you have general questions, please call 541-472-4880.
- If you have patient billing and insurance questions, please call 541-472-4895.

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Notice of Ownership
Financial Interest

For a verbal list of physician owners, please call 541-472-4880

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
Denard, Patrick MD	2780 E Barnett Road	Medford, Oregon 97504
Eagan, Thomas, DO	1075 SW Grantsview Ave. Ste. 200	Grants Pass, Oregon 97527
Greive, Melissa DO	1600 NE 6th Street, Ste. N	Grants Pass, Oregon 97526
Medley, Tamara MD	1075 SW Grandview Ave., Ste. 200	Grants Pass, Oregon 97527
Mateja, Brian DO	509 E Main St.	Rogue River, Oregon 97537
Metwally, Yaser MD	707 Murphy Creek Rd.	Medford, Oregon 97504
Perry, Bruce MD	1619 NW Hawthorne, Ste. 102	Grants Pass, Oregon 97526
Pitzak, Andrew DO	495 SW Ramsey Ave.	Grants Pass, Oregon 97527
Simchuk, Mark DPM	1619 NW Hawthorne, Ste. 106	Grants Pass, Oregon 97526
Van Horne, James MD	702 SW Ramsey Ave., Ste. 112	Grants Pass, Oregon 97527

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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Acknowledgement 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 physicians 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 employee's 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 Acknowledgement and Concent 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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Standard of Patient's Rights and Responsibilities

Standard 1
The patient will receive the care necessary to help regain or maintain maximum state of health and, if necessary, cope with death.

Standard 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.

Standard 3
The patient will be treated with consideration, respect, and full recognition of individuality, including privacy in treatment and in care.

Standard 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.

Standard 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.

Standard 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.

Standard 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.

Standard 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.

Standard 9
Facility personnel will keep adequate records and will treat with confidence all personal matters that relate to the patient.

Standard 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.

Standard 11
The patient has the right to be informed of any human experimentation or other research / educational projects affecting his or her care or treatment and to refuse participation in such experimentation or research.

Standard 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.

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

Standard 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.

Standard 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.

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

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

Standard 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.

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

Standard 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.

Standard 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.

Standard 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.

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

Standard 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.
www.oregon.gov/DHS/ph/hclc

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

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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 to:

- several free aids and services to help people with disabilities to communicate with us. These aids and services include:

- free language services to people whose primary language is not English, such as:
  - qualified interpreters via telephone
  - 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: steve.loftesnes@scasurgery.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/fle/index.html

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Nondiscrimination Notice (continued)

1. Atención: Si habla español, hay disponibles servicios de ayuda con el idioma sin costo alguno para usted. Llame al 1-877-386-9235, extension 177 (TTY:711)

2. Atenção: se você fala Português os serviços estão disponíveis para ajudar com a língua sem nenhum custo para você. 1-877-386-9235, extension 177 (TTY:711)

3. Attention: Si vous parlez français, des services sont disponibles pour aider la langue gratuitement. Cadran 1-877-386-9235, extension 177 (TTY:711)

4. Atenție: Dacă vorbiți limba română, serviciile sunt disponibile pentru a vă ajuta cu limba de cost. apel 1-877-386-9235, extension 177 (TTY:711)

5. Achtung: Wenn Sie mit der Sprache Deutsch sprechen oder Ihnen Dienste zur Verfügung stellen, die für Sie kostenlos sind. Unter der Nummer 1-877-386-9235, extension 177 (TTY:711)

6. Pažnja: Ako govorite bosanskom službom da biste pomogli jezik bez naknade. Pozovi 1-877-386-9235, extension 177 (TTY:711)

7. Attenzione: se parli italiano i servizi sono disponibili per aiutare con la lingua senza alcun costo per te. Chiama il numero 1-877-386-9235, extension 177 (TTY:711)

8. Upozornenie: Ak hovoríte po slovensky, sme Vám k dispozícii bezplatný jazyk. volanie 1-877-386-9235, extension 177 (TTY:711)

9. Merk: Hvis du snakker, er norske tjenester tilgjengelige for å hjelpe deg med språk uten kostnad for deg. Ringe 1-877-386-9235, extension 177 (TTY:711)

10. Obs! Om du talar är svenska tjänster tillgängliga för att hjälpa till med språket utan kostnad för dig. Ringa 1-877-386-9235, extension 177 (TTY:711)

11. Bemærk: Hvis du taler dansk, kan du bruge sprog gratis. Opkald 1-877-386-9235, extension 177 (TTY:711)

12. Perhatian: Jika Anda berbicara bahasa Indonesia, Anda dapat membantu menggunakan bahasa tanpa biaya. panggilan 1-877-386-9235, extension 177 (TTY:711)

13. Pange tähele: kui te räägite abi saamiseks kättesaadavatest Eesti teenustest, on keel teile tasuta. Helistama 1-877-386-9235, extension 177 (TTY:711)

14. Uwaga: Jeśli mówisz, polskie usługi są dostępne, aby pomóc w języku bez żadnych kosztów. Zadzwoń pod ten numer 1-877-386-9235, extension 177 (TTY:711)

15. Figyelem: ha magyarul beszélsz, a rendelkezésre álló szolgáltatások a nyelvek. 1-877-386-9235, extension 177 (TTY:711)

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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. Living wills or Power of Attorney forms can be used in lieu of an advanced directive. 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 we have received a copy of the patient's requests, it should be transported with them to the higher level of care. 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 Directive 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.

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Endoscopy–Colonoscopy Pre-Registration Information

One of our highly skilled nurses will contact you by telephone a minimum of 4-5 business days in advance of your scheduled procedure to cover your pertinent medical history. Due to our continually changing schedule, your time may change. You will be contacted by a member of our clinical team 4-5 business days prior to your procedure to inform you of your arrival time.

PLEASE FOLLOW THE INSTRUCTIONS 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 colon prep instructions.**
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 physicians instructions. If you have not received any instructions please take all medications **except - insulin, hypoglycemics 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 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.

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Patient Registration, Financial and Insurance Information

Patient Information:

Last name _____ First _____ Middle _____

Date of Birth _____ Social Security # _____ ☐ Male ☐ Female

Mailing Address _____ City _____ State _____ Zip _____

Home Address _____ City _____ State _____ Zip _____

Cell Phone _____ OK to leave voicemail? ☐ Yes ☐ No

Home Phone _____ OK to leave voicemail? ☐ Yes ☐ No

Email _____

Primary Care Physician _____

Surgery Information:

Procedure(s) you are having _____

_____

Surgery / Procedure Date _____ Surgeon's Name _____

Disclosure of Health Information:

With whom may we discuss your care?

Name _____ Relationship _____ ☐ All ☐ Ride Only

Phone _____

Name _____ Relationship _____ ☐ All ☐ Ride Only

Phone _____

OHRP Information: (required by State)

Race: ☐ American Indian or Alaskan Native ☐ Black or African American
☐ White ☐ Asian ☐ Prefer not to answer

Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Unknown ☐ Prefer not to answer

Responsible Party Information: (Person taking financial responsibility)

Last name _____ First _____ Date of Birth _____

Social Security # _____ Home Phone _____

Mailing Address _____ City _____ State _____ Zip _____

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Patient Registration, Financial and Insurance Information

Primary Insurance Information (Bring your insurance card(s) with you)

Insurance Company: _____ Insurance Phone: _____

Insurance Co. Address: _____ City _____ State _____ Zip _____
Street / P.O. Box #

Group Number: _____ Policy Number: _____

Policy Holder's Name: _____

Policy Holder's SSN: _____ Policy Holder's Date of Birth: _____

Secondary Insurance Information (Bring your insurance card(s) with you)

Insurance Company: _____ Insurance Phone: _____

Insurance Co. Address: _____ City _____ State _____ Zip _____
Street / P.O. Box #

Group Number: _____ Policy Number: _____

Policy Holder's Name: _____

Policy Holder's SSN: _____ Policy Holder's Date of Birth: _____

Workman's Comp / Injury Insurance

Insurance Company: _____ Insurance Phone: _____

Insurance Co. Address: _____ City _____ State _____ Zip _____
Street / P.O. Box #

Group Number: _____ Policy Number: _____

Policy Holder's Name: _____

Policy Holder's SSN: _____ Policy Holder's Date of Birth: _____

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PATIENT INFORMATION

Patient Registration Signatures

Patient's Last Name _____ First _____ Middle _____

Date of Birth _____ Social Security _____

_____ Patient Initial **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 **BLOOD PRODUCTS** I understand that in an event of blood and/or blood products would be deemed necessary or advisable for my care, I will be transferred to a higher level of care.

_____ 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 **QPIP DISCLOSURE** You acknowledge that your physician may participate in one or more quality and efficiency programs operated by your health insurer. These programs provide a financial incentive to participating physicians to achieve certain quality targets and to select cost effective, participating facilities for your care. This facility is one such participating facility. The incentive is in addition the physician's normal facility fee.

If your physician participates in such a quality and efficiency program and that program is applicable to your care at the facility, alternative referrals will be made by your physician upon request. You further acknowledge that your physician may own an interest in the facility. Further information may be obtained from the business office.

☐ 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.

☐ By signing below, I acknowledge that I have read and understand the disclosures set forth above.

_____ Patient's Signature

_____ Witness to Patient's Signature

_____ Parent/Legal Guardian's Signature
(If patient is under 14 years of age or otherwise unable)

_____ Date:

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Pre-Surgery Evaluation

Patient's Last Name _____ First _____ Middle_____ Date of Birth _____

Are you allergic to any medicines?

Name of Medication _____ Reaction _____

Name of Medication _____ Reaction _____

Please indicate whether you <u>have</u> or <u>have not</u> had the following conditions:

General

Weight _____ Height _____

Are you pregnant ☐ Yes ☐ No
Are you taking blood thinners or aspirin? ☐ Yes ☐ No

Heart

Blocked artery: Heart/Neck/Limb *(circle one)* ☐ Yes ☐ No
Heart Attack ☐ Yes ☐ No
Chest Pain/Angina ☐ Yes ☐ No
Heart Murmur ☐ Yes ☐ No
Congestive heart failure ☐ Yes ☐ No
Irregular heart beat ☐ Yes ☐ No
Coronary artery disease ☐ Yes ☐ No
High blood pressure ☐ Yes ☐ No
Heart valve disease ☐ Yes ☐ No
Rheumantic fever ☐ Yes ☐ No
Heart surgery When_____ ☐ Yes ☐ No
Pacemaker or Implanted defibrillator ☐ Yes ☐ No
Do you use an inhaler/breathing treatment? ☐ Yes ☐ No

Lung

Asthma ☐ Yes ☐ No
Emphysema ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No
TB ☐ Yes ☐ No
Sleep Apnea ☐ Yes ☐ No
Shortness of breath? At rest / with activity ☐ Yes ☐ No
Pneumonia in the past 6 months ☐ Yes ☐ No
Recent respiratory infection ☐ Yes ☐ No
Chronic or current cough ☐ Yes ☐ No
Do you use oxygen at home? ☐ Yes ☐ No
Do you use an inhaler/breathing treatment? ☐ Yes ☐ No

Other Conditions

Hiatal hernia ☐ Yes ☐ No
Gastric reflux / heartburn *(circle one)* ☐ Yes ☐ No
Jaundice ☐ Yes ☐ No
Cirrhosis ☐ Yes ☐ No
Kidney problems or stones ☐ Yes ☐ No
Thyroid disease ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Controlled by:
☐ diet ☐ oral agent ☐ Insulin
Steroids or cortizone in the past 6 months ☐ Yes ☐ No
Bad reaction to anesthesia ☐ Yes ☐ No
Seizures ☐ Yes ☐ No
Stroke / TIA When_____ ☐ Yes ☐ No
Paralysis ☐ Yes ☐ No
☐ numbness ☐ weakness Where?_____
Arthritis ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
☐ Radiation ☐ Chemotherapy
Bleeding tendency ☐ Yes ☐ No
Senile dementia/Alzheimers *(circle one)* ☐ Yes ☐ No
Hard of hearing / Deaf *(circle one)* ☐ Yes ☐ No
Blindness or injury to eye – L / R *(circle one)* ☐ Yes ☐ No
Anxiety / Panic attacks *(circle one* ☐ Yes ☐ No
Claustrophobia ☐ Yes ☐ No
Any history of MRSA? ☐ Yes ☐ No

Do You

Drink Alcohol? How much? _____ ☐ Yes ☐ No
Smoke? How much? _____ ☐ Yes ☐ No
How long have you smoked? _____
When did you quit? _____
Use street drugs? ☐ Yes ☐ No
Which? _____

Grants Pass
SURGERY CENTER
Ph. 541.472.4880
Fax. 541.472.4899
1601 N.W. Hawthorne Ave. • Grants Pass, Oregon 97526 • www.gpsurgerycenter.com

PATIENT INFORMATION

Medication / Hospitalization Summary

Patient's Last Name _____ First _____ Middle _____

Date of Birth _____ Social Security _____

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.

Previous Hospitalizations and/or Surgeries in the last 10 years (If additional check here ☐)

Type_____ Date (month and year) _____

Type_____ Date (month and year) _____

Type_____ Date (month and year) _____

Type_____ Date (month and year) _____

Type_____ Date (month and year) _____

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).

Current Medications (☐ check - additional on reverse side)

Name of Medication _____

Dosage _____ Frequency_____ Time of day _____ ☐ AM ☐ PM

Name of Medication _____

Dosage _____ Frequency_____ Time of day _____ ☐ AM ☐ PM

Name of Medication _____

Dosage _____ Frequency_____ Time of day _____ ☐ AM ☐ PM

(☐ check - additional on reverse side)

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PATIENT INFORMATION

Medication / Hospitalization Summary (continued)

Current Medications

Name of Medication ______________________________

Dosage ____________ Frequency ____________ Time of day ________ ☐ AM ☐ PM

Name of Medication ______________________________

Dosage ____________ Frequency ____________ Time of day ________ ☐ AM ☐ PM

Name of Medication ______________________________

Dosage ____________ Frequency ____________ Time of day ________ ☐ AM ☐ PM

Name of Medication ______________________________

Dosage ____________ Frequency ____________ Time of day ________ ☐ AM ☐ PM

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Dosage ____________ Frequency ____________ Time of day ________ ☐ AM ☐ PM

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Name of Medication ______________________________

Dosage ____________ Frequency ____________ Time of day ________ ☐ AM ☐ PM

Name of Medication ______________________________

Dosage ____________ Frequency ____________ Time of day ________ ☐ AM ☐ PM

Name of Medication ______________________________

Dosage ____________ Frequency ____________ Time of day ________ ☐ AM ☐ PM