Robert T. Stroup, Jr., M.D. FACS

Dear Patient,

The following information is our office policy for all insurance billing.
Please read carefully.

REFERRALS

All referrals from your primary care provider (PCP), if required by your insurance policy, must be in place **prior** to your office visit. If the referral is not in place, you will be responsible for your office visit payment at the time of visit.

If your bill is denied due to "no referral from PCP" please call your insurance company and/or your PCP to handle this.

COPAYS & DEDUCTIBLES

All co-pays and deductibles are due at the time of service. These fees are set by your insurance company and we are legally bound to bill according to the insurance contract without discounting. Again, if you have a dispute with the billed amount, please contact your insurance company, not our office. Any past due deductibles or co-pays, regardless of the amount, will be sent to our collection agency.

CLAIMS

Our office will bill your primary insurance. If your claim is unpaid at three months after we submit the claim, you will be responsible for services that were rendered. We will bill you at that point and you can then follow up with your insurance company for payment.

Our office will also bill your secondary insurance company but only one time. Again, if there is no payment or response within three months, you will become responsible for that portion of the bill.

Your signature below signifies that you have read and understand this policy.

X____

Patient's Signature

Health History

Name: ____

Age: ______________ Height: ____________ Weight: ________________

Date of Last Physical: ______________ Date of Last Chest X-ray: ______________

Date of Last EKG: ___________ Do you smoke or use tobacco? _____ If yes, how much?_____

Do you drink alcohol? ______________ If yes, how much?____________________

Would you like a chaperone present during your exam with Dr. Stroup? YES NO

Asthma	YES	NO	Pain Pills/Shots	YES	NO
Pulmonary Embolus	YES	NO	Hay Fever	YES	NO
Pneumonia, Tuberculosis	YES	NO	Emphysema	YES	NO
Shortness of Breath	YES	NO	Rheumatic Fever	YES	NO
Mental/Emotional Illness	YES	NO	Anemia	YES	NO
High Blood Pressure	YES	NO	Stroke/Dizziness	YES	NO
Low Blood Pressure	YES	NO	Diabetes	YES	NO
Convulsions/Epilepsy	YES	NO	Heart Attack	YES	NO
Cancer Chemotherapy	YES	NO	Pacemaker	*YES	NO

*If yes, who is your cardiologist? ____________

Do you have any other illness/medical conditions not mentioned above? __________________

Are you allergic to any medications? YES NO If yes, which ones? ____________________

____

Have you recently taken any medications? YES NO If yes, which ones? ________________

____

Do you take vitamins or herbals? YES NO If yes, which ones? ____________________

____

Do you have a history of cold sores, herpes, or similar lesions? YES NO

Are you taking any of these medications?

Blood Thinners	YES	NO	Anticoagulants	YES	NO	Aspirin	YES	NO
Ibuprofen	YES	NO	Steroids	YES	NO	Cortisol	YES	NO
Medrol	YES	NO	Prednisone	YES	NO			

Please list any previous surgeries. ______________________________________

____

____

Did you experience any postoperative nausea following these surgeries? YES NO

FEMALES: Are you pregnant? YES NO Number of Pregnancies:___ Number of Children:___

When was your last mammogram? ____________________________

Breast Surgery Consultation Only: Bra Size: _____ Would like to be: ___________

Do you do self-exams on a regular basis? YES NO

Is there a history of breast cancer in your family? YES NO

Do you have a history of breast problems (ie. cysts, bumps, etc.)? YES NO

I have answered the questions concerning my health to the best of my knowledge.

____

Patient's Signature Date

Patient Information

Name: ____________________ Would you like to be addressed by your first or last name in the waiting area? Please circle.
FIRST LAST

Address: ____________________ Is this the address you would like correspondence and billings sent to? YES NO

City: __________ State: ____ Zip: ______

May we leave messages at these following numbers?
(appointment reminders, lab & x-ray results, etc.)

Home Phone: ____________________ YES NO

Work Phone: ____________________ YES NO

Cell Phone: ____________________ YES NO

Email Address: ____________________ May we send you information via email? YES NO

Date of Birth: ____________________ SSN: ____________________

Marital Status: S M W D MALE FEMALE (Please Circle)

Occupation: ____________________

Name of Employer: ____________________

REASON FOR TODAY'S VISIT: ____________________

How did you hear about our office? ____________________

If you were referred by a physician, please provide their name.
Physician's Name: ____________________

Primary Care Physician: ____________________ Phone #: ____________________

Please check here if you would like us to submit your charges to your health insurance company and please provide us with a copy of your card & sign our insurance filing policy located on the back side of this sheet.
If your insurance policy is in someone else's name, please fill in the information below.

Name: ____________________ Date of Birth: ____________________

Address: ____________________ SSN: ____________________

City: __________ State: ____ Zip: ______ Relation: Spouse - Parent - Guardian
(please circle)

Marital Status: S M W D Male Female Name of Employer: ____________________

I have answered the above information to the best of my knowledge.

____

Patient's Signature Date