

KISSIMMEE SURGERY CENTER REGISTRATION FORM
2275 North Central Avenue, Kissimmee, FL 34741
(407) 870-0573

Previous admission to KISSIMMEE SURGERY CENTER? If so, when _____

Patient Name _____
(Last Name) (First Name) (Middle Initial)

Parents' Name (if patient is minor) _____

Address _____
(Street or P O Box) (City, State, Zip Code)

Social Security No. _____ Date of Birth _____ Age _____

Home Phone No. _____ Work Phone No. _____ Extension _____

Marital Status: (Circle) Single Married Divorced Widowed Employer _____

Employment: (Circle) Full Time Part Time Not Employed Self Employed Retired Active Military

Spouse Name _____ Emergency Contact Name and Number _____

INSURANCE INFORMATION

Primary Insurance _____ Insured Name: _____

ID NO. _____ Group No. _____ Employer _____

Claim Address: _____

Secondary Insurance _____ Insured Name: _____

(If applicable)
ID NO. _____ Group No. _____ Employer _____

Claim Address: _____

MEDICARE SECONDARY PAYOR SCREENING (Please complete if you have Medicare)

1. Are you currently receiving Medicare Benefits? **Yes or No** (If Yes, Please Answer Questions 2,3,and 4)
2. Are either you or your spouse currently working? **Yes or No**
3. Are either you or your spouse currently provided with any group health coverage? **Yes or No**
4. Are you currently receiving any other health care benefits (i.e., Black Lung, Veterans Affairs, Government research grant, work, non-work, or automobile accident related injury or illness benefits?) **Yes or No**

IS THIS VISIT WORK RELATED? Yes No IS THIS VISIT RELATED TO AN AUTO ACCIDENT? Yes No
If Yes, Date of Injury/Accident: _____ Employer (if work related) _____

ADVANCED DIRECTIVES

1. YES, I DO _____ or NO, I DO NOT _____ have an Advanced Directive, Living Will or Healthcare Power of Attorney. (If yes, another form will be provided for your review and acknowledgement)

2. YES, I DO _____ or NO, I DO NOT _____ want to have information on Advanced Directives
(If yes, then a brochure will be made available to you for your review)

State of Florida requires health care providers to report patient demographic information quarterly. Please circle the appropriate Classification as it applies to the PATIENT ONLY from the following list as supplied by the State of Florida.

AMERICAN INDIAN ASIAN/PACIFIC BLACK BLACK HISPANIC WHITE HISPANIC WHITE OTHER

PATIENT SIGNATURE: _____ DATE: _____

Kissimmee Surgery Center

Patient Pre and Post Assessment

Anesthesia Services

Diagnosis: _____
 Proposed Surgery: _____

yes	no	
<input type="checkbox"/>	<input type="checkbox"/>	Previous Kissimmee Surgery Center visits? Date of Last Visit: _____
<input type="checkbox"/>	<input type="checkbox"/>	Previous hospitalization (other than surgery)? List: _____
<input type="checkbox"/>	<input type="checkbox"/>	Previous surgeries? List: _____
<input type="checkbox"/>	<input type="checkbox"/>	Previous problems with anesthesia?
<input type="checkbox"/>	<input type="checkbox"/>	Family history of anesthesia problems?
<input type="checkbox"/>	<input type="checkbox"/>	Medical test within last 6 months? (x-rays, EKG, labs)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> At Kissimmee Surgery Center?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> At other location? _____
<input type="checkbox"/>	<input type="checkbox"/>	Any special spiritual, physical, or cultural needs which should be considered?
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to medication, for or other substances? List: _____
<input type="checkbox"/>	<input type="checkbox"/>	Medications currently taking? (include herbal products and appetite suppressants)

<input type="checkbox"/>	<input type="checkbox"/>	Recent exposure to contagious disease such as TB, chicken pox, measles
<input type="checkbox"/>	<input type="checkbox"/>	Skin problems (rash, sores, discolorations)
<input type="checkbox"/>	<input type="checkbox"/>	Eye problems (cataracts, sight loss, glaucoma)
<input type="checkbox"/>	<input type="checkbox"/>	Ear problems (hearing loss, ringing in ears, pain)
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty chewing, swallowing, or breathing through nose
<input type="checkbox"/>	<input type="checkbox"/>	Recent sore throat or voice change
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath at rest or with minor activity
<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth, dentures, caps, bridges, contact lenses? (Circle one or more)
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing (asthma or emphysema)
<input type="checkbox"/>	<input type="checkbox"/>	Smoking: Amount _____ Number of years: _____
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain (heart attack, angina, other)
<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur or heart-rhythm irregularity
<input type="checkbox"/>	<input type="checkbox"/>	Pain legs at rest or with activity
<input type="checkbox"/>	<input type="checkbox"/>	Blood pressure problems
<input type="checkbox"/>	<input type="checkbox"/>	Using a pacemaker? Last time checked: _____
<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles/legs
<input type="checkbox"/>	<input type="checkbox"/>	Stomach or bowel problems (pain, nausea, vomiting, diarrhea, bloody stools)
<input type="checkbox"/>	<input type="checkbox"/>	Unusual increase or decrease in weight or loss of appetite
<input type="checkbox"/>	<input type="checkbox"/>	Liver or gallbladder problems (stones, hepatitis, cirrhosis)

yes	no	
<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid diseases
<input type="checkbox"/>	<input type="checkbox"/>	Lives alone
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Seizures or convulsions
<input type="checkbox"/>	<input type="checkbox"/>	Kidney or urinary problems (stones, infection, kidney failure)
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal vaginal bleeding or unusual pelvic pain
<input type="checkbox"/>	<input type="checkbox"/>	Pregnant? Due date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Bone, nerve, joint, muscle problems
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty walking or getting in/out of bed or chair
<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches or migraines
<input type="checkbox"/>	<input type="checkbox"/>	Fainting or dizzy spells
<input type="checkbox"/>	<input type="checkbox"/>	Unusual anxiety depression, sleep or mood changes
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol intake _____
<input type="checkbox"/>	<input type="checkbox"/>	Marijuana, cocaine, other _____
<input type="checkbox"/>	<input type="checkbox"/>	Treatment for emotional/psychological disturbances
<input type="checkbox"/>	<input type="checkbox"/>	Anemia, low blood count
<input type="checkbox"/>	<input type="checkbox"/>	Unusual bruising or bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Nauseated or vomited after anesthesia
<input type="checkbox"/>	<input type="checkbox"/>	Motion sickness, such as seasickness

Do not write below this line

PHYSICAL EXAMINATION: Height: _____ Weight: _____

Airway Evaluation: Grade 1 2 3 4 Comments:
 Chest: _____
 Neuro: _____

Heart: _____
 Other: _____

ASA Classification: 1 2 3 4 5
 NPO Status: _____

Medical Considerations Affecting Anesthetic Plan:
 Cardiopulmonary compromise Airway compromise Full stomach
 Electrolyte imbalance Postoperative Nausea/Vomiting Obesity

Acceptable Candidate for Anesthesia? yes no
 Comments: _____

Type: General Spinal MAC Block Epidural

Full plan of anesthesia was explained to the patient/family, as well as risks, complications, and alternatives. Patient/family agrees with and understands the above mentioned plan.

Date: / / Signature: _____

POSTOP NOTE: Patient discharged in satisfactory condition. Aldrete Score satisfied.

Date: / / Signature: _____