BERWALD SURGICAL MEDICAL, INC.

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3478 BRIDGELAND DRIVE
BRIDGETON, MO 63044
314-739-8200

Thank you for choosing Berwald Surgical Medical as your Provider of medical care. We pride ourselves on the care we provide and our office is run with respect and consideration to our patients. Please keep in mind the following instructions so we can better care for your medical needs.

- Notify the front desk upon sign in of any changes to your medical insurance or personal information and have your insurance card available for us to copy

- If required by your insurance plan, make sure we are listed as your primary care doctor by notifying your insurance carrier prior to making an appointment with us.

- All routine referrals require one week to process. Please call with all information at least one week prior to the appointment date. Necessary information includes the Doctors full name, appointment date, location, phone and fax numbers as well as the ICD-10 code.

- All co-pays are due at the time of your office visit.

- Please bring all medicine to your first Doctor visit.

- We may wish to request records from your previous Doctor(s). Please bring their contact information to your first appointment.

- New patient appointments require verbal confirmation either at the time of your reminder call or a return call to us. If we do not speak to you directly, prior to the morning of your appointment, your appointment will be canceled.

The physicians and staff of Berwald Surgical Medical would like to thank you for choosing us to help manage your medical needs.

Patient signature: _____

HEALTH QUESTIONNAIRE Date_____

Please complete this entire questionnaire. It will provide your care team with important information about your health. All answers are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.):_____ **M F DOB:** _____

Street Address: _____**City** _____**State** _____ **Zip** _____

Home Phone:_____ **Cell Phone** _____ **email address**_____

Social Security # _____ - ____ - _____

Marital Status: ___Single ___Partnered ___Married ___Separated ___Divorced ___Widowed

Employer_____Occupation is/was: _____

Emergency contact: _____ Phone #(s):_____

PHARMACY INFORMATION

Pharmacy Name _____ Address _____

Phone # _____ _____

RESPONSIBLE PARTY (if other than self)

Parent/Guardian Full Name_____ Relationship to patient _____

Date of birth_____ Primary phone #_____

Address _____ Email Address _____

PRIMARY INSURANCE

Insurance Company_____

Member ID_____

Group Number_____

Street Address_____

City, State, Zip_____

Name (as shown on card) _____

SECONDARY INSURANCE

Insurance Company _____

Policy Number _____

Group Number_____

Street Address_____

City, State, Zip_____

Name (as shown on card)_____

POLICY HOLDER INFORMATION (if different than patient)

Name (as shown on card) _____Address _____

SSN _____ _____

Date of Birth_____Primary Phone #_____

PREVIOUS PRIMARY CARE INFORMATION

Physician Name_____Phone #_____

SPECIALIST(s) seen in the last 12 months and for what reason

Specialist _____Phone # _____

Specialist _____Phone # _____

Specialist _____Phone # _____

HOSPITALIZATIONS / SURGERIES

Year_____ Hospital_____ Reason_____

Year_____ Hospital_____ Reason_____

Year_____ Hospital_____ Reason_____

PATIENT MEDICAL INFORMATION

Please help the doctor by filling out your medical history as completely as possible

Please check all of the conditions that apply to you:

Asthma or Emphysema _____Yes____No_____Sometimes
Short of breath _____Yes____No_____Sometimes
Sinus problems _____Yes____No_____Sometimes
Dental problems _____Yes____No_____Sometimes
Ear/Nose/Throat problem _____Yes____No_____Sometimes
Anxiety/Depression _____Yes____No_____Sometimes
Skin problems _____Yes____No_____Sometimes
Diabetes _____Yes____No_____Sometimes
Thyroid Disorder _____Yes____No_____Sometimes
Kidney/Bladder problem _____Yes____No_____Sometimes
Gastrointestinal issues _____Yes____No_____Sometimes
High Blood Pressure _____Yes____No_____Sometimes
Heart trouble/Stroke _____Yes____No_____Sometimes
Osteoporosis _____Yes____No_____Sometimes
Weight Loss/Weight Gain _____Yes____No_____Sometimes
Cancer _____Yes____No_____Sometimes

Family history (if yes-relationship):

Diabetes ___Yes___No: Relationship:_____
Prostate cancer ___Yes___No: Relationship:_____
Breast cancer ___Yes___No: Relationship:_____
Colon cancer ___Yes___No: Relationship:_____
Other cancer _____ ___No: Relationship:_____
Mental Illness ___Yes___No: Relationship:_____
Heart issue ___Yes___No: Relationship_____
Heart Attack/Stroke ___Yes___No: Relationship_____
Rheumatoid Arthritis___Yes___No: Relationship_____
Other family medical problems: _____
_____
_____
_____
_____
_____
_____

Are you currently being treated for any other medical conditions? ____Yes____No If yes, please describe:

Please list date of most recent:	**Current Medications**	**Dose**	**Frequency**
Eye Exam _____	_____		
Colonoscopy _____	_____		
Bone density __ _____	_____		
Tetanus booster/TDAP _____	___ _____		
Zoster (Shingles) vaccine _____	_____		
Pneumonia vaccine _____	_____		
COVID vaccine _____	_____		
Other vaccine(s) _____	_____		
	_____		
	_____		

Do you currently live alone? ____Yes____No
Are you currently pregnant or nursing?____Yes____No
Do you smoke or use tobacco? ____Yes____No If yes, packs per day _____ Number of years _____
If ex-smoker when did you quit _____
Do you drink alcohol? ____Yes____No If yes, drinks per week _____
Are you allergic to any medications? ____Yes____No If yes, please list and give reactions: _____

_____

_____

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3478 Bridgeland Drive
Bridgeton, MO 63044

Have you received a copy of the Privacy Act?

Yes _____√_____ No _____

List names and relationship of those we may share your personal health information with:

1_____Phone #_____

2_____Phone #_____

3_____Phone #_____

May we leave your personal health information on your answering machine?

Yes_____ No_____

Signature _____ Date _____

PAYMENT POLICY

Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read, ask questions and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance:** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles:** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. We accept cash, check, Visa and Master Card. We no longer accept credit or debit card payments for less than $10.

3. **Non-covered services:** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit.

4. **Proof of insurance:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claim Submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment:** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and a $25% fee will be added to the balance.

8. **Missed appointments:** Our policy is to charge for missed appointments or those not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you and others better by keeping your scheduled appointment.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read an understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

3478 Bridgeland Dr Bridgeton, MO 63044

Notes:
FROM I270: Take St Charles Rock Rd. east to right on McKelvey then left on Bridgeton Square. Second building on the right one block down

FROM I70: Take St Charles Rock Rd. west to left on McKelvey then left on Bridgeton Square. Second building on the right one block down