Advanced Surgery

GLENN L. SANDLER, M.D.

Dear Patient:

Your appointment is scheduled for

Rockville Office: 9715 Medical Center Drive, Suite 233 Rockville, MD 20850

** **Please plan to arrive 15 minutes prior to your scheduled appointment time.**

We request updated forms be completed when your information has changed or once a year.

Please be sure to bring all items that apply:

- ✓ Completed Forms that are enclosed
- ✓ Diagnostic Imaging and/or Procedure Reports with corresponding written reports(s), if any. Ex. Mammo/US, Colonoscopy/EGD Procedure Reports w/ Color Photos. **(You will need to pick up these items from the facility where you had them performed.)**
- ✓ Lab results, if any. **(You will need to obtain a copy of the results from the physician who ordered them.)**
- ✓ Insurance Card(s)
- ✓ Current Drivers License or Photo ID
- ✓ Referral from your Primary Care Physician **(If required-you may need to call your insurance company if you are unsure.)**
- ✓ Method of payment: cash, check, Visa, MasterCard, Discover **(If your insurance plan requires a co-payment.)**

Please note a $25 charge will be applied for ALL missed appointments and/or appointments cancelled without a 24 hour business day prior notice.

If you have any questions please contact our office at 301.251.4128 Monday-Friday from 8:30am-4:30pm.

Sincerely,

Advanced Surgery, PC

ADVANCED SURGERY, PC

GLENN SANDLER MD

Today's Date: (Please Print) For office Use: GS ☐ ☐

PATIENT INFORMATION

Primary Care Physician or Group:	Referring Physician:

First Name:	**MI:**	**Last Name:**	**Preferred Name:**
☐ **Mr.** ☐ **Mrs.** ☐ **Miss** ☐ **Ms.** ☐ **Sr.** ☐ **Jr.** ☐ **III**			
Street address:		**City:**	**County:**
Street address 2:		**State:**	**ZIP Code:**
Home no.:	**Cell no:**	**Birth date:**	**Age:**
Work no.:	**Email:** @	**Social Security #:**	

Sex: ☐ **M** ☐ **F** **Marital Status:** **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Widowed** ☐ **Partnered** ☐

Race: ☐ **Black** ☐ **Chinese** ☐ **Filipino** ☐ **Hispanic** ☐ **Indian** ☐ **Native American** ☐ **Native Hawaiian** ☐ **Other** ☐ **Asian** ☐ **Pacific Islander** ☐ **Caucasian**

Occupation:	**Employer:**	**Status: FT** ☐ **PT** ☐ **Ret** ☐ **Tmp** ☐ **Other:** ☐
Employer Address:	**City:**	**County:**
Employer Address 2:	**State:**	**ZIP Code:**

INSURANCE INFORMATION (Please give your insurance cards to the receptionist.)

Is this visit related to a work injury (Workman's Compensation)	☐ YES ☐ NO	☐ HMO ☐ PPO ☐ POS ☐ Open Access
Primary Insurance Name		**Telephone #:**
Street address:	**City:**	**State:** **ZIP:**

Subscriber's name: (If different from above)	**Subscriber's S.S. no.:**	**Birth date**:	**Policy no.**:	**Group no.:**

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other **Sex:** ☐ **M** ☐ **F**

Subscribers Place of Employment: Tel Number:

Secondary Insurance Information

Secondary Insurance Name		**Telephone #:**	☐ HMO ☐ PPO ☐ POS ☐ Open Access
Street address:		**City:**	**State:** **ZIP:**

Subscriber's name: (If different from above)	Subscriber's S.S. no.:	Birth date:	Policy no.:	Group no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other **Sex:** ☐ **M** ☐ **F**

Subscribers Place of Employment: Tel Number:

EMERGENCY CONTACT

I authorize verbal release of personal health information relevant to my care, such as test results, appointment information, etc. to the following individuals:	**Relationship to patient:**	**Cell phone no.:**	**Work/Home**

☐ YES ☐ DO NOT Leave a message on my answering machine/voice mail/email or with anyone in my household who answers the phone.

Advanced Surgery, PC
Dr. Glenn Sandler

HEALTH HISTORY QUESTIONNAIRE

Date:_____

All questions contained in this questionnaire are strictly confidential and will become part of your medical records

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

Marital status: ☐ **Single** ☐ **Partnered** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Pharmacy Name and Address: **Pharmacy Phone number:**

PLEASE DESCRIBE THE REASON FOR YOUR VISIT TODAY

PLEASE LIST YOUR MEDICATIONS AND DOSAGES (Please attach additional sheet if necessary)

Medication Name	Strength (MG)	Times per day	Referring Physician

ALLERGIES TO MEDICATIONS ☐ None

Name of Drug	Reaction You Had

Are you allergic or sensitive to LATEX? ☐ **Yes** ☐ **No**

PAST MEDICAL HISTORY (Please check all that apply)

☐ None	☐ Colitis	☐ Heart murmur	☐ MI/Heart attack	☐ Rheumatoid arthritis
☐ ADD	☐ Colon cancer	☐ Hepatitis A	☐ Migraine	☐ Seizure disorder
☐ Alzheimer's/Dementia	☐ Congestive Heart Failure	☐ Hepatitis B	☐ Mitral valve prolapse	☐ Sleep apnea
☐ Anemia	☐ COPD	☐ Hepatitis C	☐ Multiple sclerosis	☐ Stomach cancer
☐ Angina	☐ Coronary Artery Disease	☐ Herpes	☐ Osteoarthritis	☐ Stomach ulcer
☐ Anxiety	☐ Crohn's disease	☐ Hiatal hernia	☐ Osteoporosis	☐ SVT
☐ Aortic aneurysm	☐ CVA/Stroke	☐ High blood pressure	☐ Ovarian cancer	☐ Thyroid cancer
☐ Arthritis	☐ Depression	☐ High cholesterol	☐ Ovarian cysts	☐ Urinary infection-chronic
☐ Asthma	☐ Diabetes Type 1	☐ HIV/Aids	☐ Parkinson's disease	☐ Ulcerative colitis
☐ Atrial fibrillation	☐ Diabetes Type 2	☐ Hyperthyroidism	☐ **Presently pregnant**	☐ Urinary incontinence
☐ Blood clotting issues	☐ Diverticulitis	☐ Hypothyroidism	☐ Prostate cancer	☐ **Use Coumadin**
☐ Bowel obstruction	☐ Endometriosis	☐ Irritable bowel syndrome	☐ Prostate enlarged	☐ **Use Plavix**
☐ Breast cancer	☐ Fibromyalgia	☐ Kidney stones	☐ Poor circulation	☐ **Use aspirin**
☐ Cervical cancer	☐ GI Bleed	☐ Low platelets	☐ Pulmonary embolism	☐ **Use other anticoagulant**
☐ Cirrhosis	☐ H. pylori	☐ Lupus	☐ Reaction to anesthesia	☐ Other_____
☐ Clots in legs	☐ Heartburn/Reflux	☐ Melanoma	☐ Renal failure chronic	

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Health History Questionnaire

(Continued)

Name: _____ Date:_____

PAST SURGICAL HISTORY (Please check all that apply)

- ☐ None
- ☐ Abdominal surgery exploratory
- ☐ Abdominoplasty/tummy tuck
- ☐ Angioplasty/stent
- ☐ Aortic valve replacement
- ☐ Appendectomy
- ☐ Axillary lymph node dissection
- ☐ Back surgery
- ☐ Bladder surgery
- ☐ Brain surgery
- ☐ Breast biopsy
- ☐ Breast implants
- ☐ Breast reduction
- ☐ C section
- ☐ Carotid endarterectomy
- ☐ Carpal tunnel
- ☐ Cataract extraction
- ☐ Colon resection
- ☐ Colonoscopy
- ☐ Dental surgery
- ☐ Ectopic pregnancy
- ☐ Femoral hernia
- ☐ Gallbladder removed
- ☐ Gastric bypass
- ☐ Hand/Finger surgery
- ☐ Heart bypass
- ☐ Hemorrhoidectomy
- ☐ Hip replacement
- ☐ Hysterectomy w/tubes & ovaries
- ☐ Hysterectomy w/o tubes & ovaries
- ☐ Incisional hernia
- ☐ Inguinal hernia
- ☐ Kidney removed
- ☐ Knee arthroscopy
- ☐ Knee replacement
- ☐ Lumpectomy
- ☐ Lung resection
- ☐ Mastectomy
- ☐ Mitral valve replacement
- ☐ Ovarian cyst removal
- ☐ Pacemaker
- ☐ Pancreatic surgery
- ☐ Pilonidal cyst
- ☐ Prostate removal
- ☐ Remove tubes/ovaries only
- ☐ Rotator cuff repair
- ☐ Sentinel lymph node biopsy
- ☐ Shoulder surgery
- ☐ Sinus surgery
- ☐ Small bowel resection
- ☐ Splenectomy
- ☐ Stomach(part of removed)
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Tooth extraction
- ☐ Tubal ligation
- ☐ TURBT
- ☐ TUR
- ☐ Umbilical hernia
- ☐ UPPP
- ☐ Valve replacement
- ☐ Vasectomy
- ☐ Other _____

Family History of (Please select all that apply)

☐ **None** ☐ **Unknown**

Please indicate, next to the condition, the family member who has or had the disease using the abbreviations below:

M=Mother, F=Father, S-Sister, B=Brother, MGF=Maternal Grandfather, PGF=Paternal Grandfather, MGM=Maternal Grandmother PGM=Paternal Grandmother, PU=Paternal Uncle, MU=Maternal Uncle, PA=Paternal Aunt, MA=Maternal Aunt

- ☐ Bladder cancer _____
- ☐ Breast cancer _____
- ☐ Colon cancer _____
- ☐ Crohn's disease _____
- ☐ Gastric cancer _____
- ☐ Head and Neck cancer _____
- ☐ Kidney cancer _____
- ☐ Liver cancer _____
- ☐ Lung cancer _____
- ☐ Lymphoma _____
- ☐ Melanoma _____
- ☐ Ovarian cancer _____
- ☐ Pancreatic cancer _____
- ☐ Prostate cancer _____
- ☐ Reaction to anesthesia _____
- ☐ Stomach cancer _____
- ☐ Thyroid cancer _____
- ☐ Ulcerative colitis _____
- ☐ Uterine cancer _____
- ☐ Other _____

Social History (Please check each column)

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Partnered

Employment status:
- ☐ Employed
- ☐ Not employed
- ☐ Self employed
- ☐ Stay at home mom
- ☐ Retired
- ☐ Student

Tobacco (choose one)
- ☐ Current every day smoker
- ☐ Current some day smoker
  - ☐ Cigarettes Amount___ pks/day
  - ☐ Cigars Amount___ #/week
  - ☐ Chew Amount___ #/day
- ☐ Former smoker: Year quit _____
- ☐ Never smoker

Do you drink alcohol?
- ☐ Yes ☐ No

If yes, what kind?

_____

drinks per day? _____

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Health History Questionnaire

(Continued)

Name: _____ Date: _____

Height and Weight

Height: _____ Weight: _____

Please check off all that apply for each body system

General complaints of:

- ☐ No Complaints of this type
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Lack of Appetite
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Fatigue
- ☐ Unable to sleep
- ☐ Weakness

Skin

- ☐ No Complaints of this type
- ☐ Rash
- ☐ Itching
- ☐ Dryness
- ☐ Yellowing Skin
- ☐ Changes in Hair
- ☐ Changes in Nails
- ☐ Changes in Moles/Lesions
- ☐ New Skin Lesions

Nervous System

- ☐ No Complaints of this type
- ☐ Difficulty with Memory
- ☐ Difficulty with Speech
- ☐ Difficulty Walking
- ☐ Fainting
- ☐ Paralysis
- ☐ Numbness
- ☐ Seizures
- ☐ Tremors
- ☐ Headaches
- ☐ Dizziness

Cardiac

- ☐ No Complaints of this type
- ☐ Chest Pains
- ☐ Heart Racing
- ☐ Shortness of Breath while lying down
- ☐ Shortness of Breath with exertion
- ☐ Swelling in legs

Breathing

- ☐ No Complaints of this type
- ☐ Cough
- ☐ Shortness of Breath in general
- ☐ Coughing up Blood
- ☐ Wheezing
- ☐ Painful Breathing

Hematologic

- ☐ No Complaints of this type
- ☐ Bruise Easily
- ☐ Bleed Easily
- ☐ Blood Clots
- ☐ Enlarged Lymph Nodes
- ☐ Bleeding Gums
- ☐ Nosebleeds

Gastrointestinal

- ☐ No Complaints of this type
- ☐ Painful Swallowing
- ☐ Heartburn
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black Stools
- ☐ Bloody Stools
- ☐ Gas/Bloating
- ☐ Change in Bowel Habit
- ☐ Difficulty Swallowing
- ☐ Yellow eyes or skin

Genitourinary

Men

- ☐ No Complaints of this type
- ☐ Painful Urination
- ☐ Bloody Urine
- ☐ Penile Discharge
- ☐ Frequent Urination
- ☐ Hesitancy in Urination
- ☐ Frequent Night Urination
- ☐ Urine Leakage
- ☐ Erectile Dysfunction

Women

- ☐ No Complaints of this type
- ☐ Vaginal Discharge
- ☐ Urine leakage
- ☐ Painful Urination
- ☐ Bloody Urine
- ☐ Frequent Urination
- ☐ Abnormal Vaginal Bleeding
- ☐ Pelvic Pain

Psychological

- ☐ No complaints of this type
- ☐ Depression
- ☐ Anxiety
- ☐ Hallucinations
- ☐ Paranoia
- ☐ Phobias

Health History Questionnaire

(Continued)

Name: _____ Date:_____

Please check off all that apply for each body system

Vascular	Muscular/Skeletal	Endocrine
☐ No Complaints of this type	☐ No Complaints of this type	☐ No Complaints of this type
☐ Blue Fingers/Toes	☐ Joint Pain	☐ Intolerance to Cold
☐ Swelling in Extremities	☐ Joint Swelling	☐ Intolerance to Heat
☐ Varicose Veins	☐ Back Pain	☐ Excessive Thirst
☐ Pain in Legs with Walking	☐ Muscle Weakness	☐ Excessive Hunger
☐ Resting leg Pain	☐ Muscle Shrinkage	☐ Excessive Urination
	☐ Muscle Cramps	

Women only

Age at onset of menstruation: _____ Date of last menstruation:_____

Number of pregnancies:_____ Number of live births:_____ Age at first live birth:_____

Are you currently breastfeeding? ☐ Yes ☐ No

Have you ever taken birth control pills or hormone therapy? ☐ Yes ☐ No

If yes, for how long? _____

Please list any physicians to whom you would like a report of your treatment sent: (write name of physician)

OB/Gyn:

Gastroenterologist:

Cardiologist:

Dermatologist:

Other:

DISCLOSURE OF PHYSICIAN OWNERSHIP

NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

1. Glenn L. Sandler, MD is owner of Montgomery Surgery Center, L.P.

2. You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than Montgomery Surgery Center, L.P.

3. You will not be treated differently by your physician if you choose to obtain health care services at a facility other than Montgomery Surgery Center, L.P.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of Montgomery Surgery Center, L.P. We welcome you as a patient and value our relationship with you.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Montgomery Surgery Center, L.P.

_____	_____
Signature of Patient	Signature of Parent or Guardian (if applicable)
_____	_____
Type or Print Name of Patient	Type or Print Name of Parent or Guardian (if applicable)

Dated:_____

Advanced Surgery, PC

GLENN L. SANDLER, MD, FACS

Financial Policy

Deductibles/Co-Insurances for Surgery:

Advanced Surgery requires you to pay any in network or out of network deductibles and/or co-insurance amounts ***prior*** to your scheduled surgery. Our billing department will contact you with an estimated amount. This is only an estimate; after we receive payment from your insurance carrier we will either bill or refund you according to your insurance explanation of benefits. We accept Visa, MasterCard, Discover or personal checks. If paying by check, we must receive payment no later than 3 days prior to your scheduled surgery.

Please note: The fees collected and billed to your insurance carrier are for your surgical procedures performed by Dr. Sandler. ***This does not include any fees you may owe to the Hospital, Ambulatory Surgical Center, Anesthesia, Pathology, Radiology or Laboratory Services, which are billed separately from our surgeon's fees.*** We do not bill or collect deductibles and/or co-insurances for any of the above-mentioned entities. If you have any questions, please contact those facilities/entities directly regarding any insurance questions you may have.

Pre-Authorization for Surgery:

Our office will contact your insurance company to obtain preauthorization for your procedure. However, this is not a guarantee that your insurance company will pay for your surgery. Patients are responsible for their benefits, coverage and payment for all services rendered by Advanced Surgery. We encourage our patients to take this opportunity to understand their personal insurance benefits. If you have any questions, you should contact your insurance carrier, employer HR Department or insurance broker to verify your benefits, eligibility and coverage.

Surgery Cancellation Policy:

Once you have selected your surgery date, any changes or cancellations must be made **Two** week prior to your procedure. Surgery scheduling requires careful planning and coordination between our office, the surgical facility and their operating room, and your insurance company. There will be a **$100 cancellation fee** for failure to cancel/changed your surgery date at least **Two** week prior to your procedure. By cancelling in a timely manner, you will allow us to offer the scheduled time to another surgical patient.

Signature of Patient

Signature of Parent or Guardian (if applicable)

Type or Print Name of Patient

Type or Print Name of Parent or Guardian

9715 MEDICAL CENTER DRIVE, SUITE 233 *ROCKVILLE, MD * 20850
PHONE: (301) 251-4128• FAX: (301) 738-1593
www.advancedsurgery.net

Advanced Surgery

GLENN L. SANDLER, MD

Directions

Rockville

P: 301-251-4128
F: 301-738-1593

9715 Medical Center Drive, Suite 233, Rockville, MD 20850

From points north or south:

Take **I-270**
Take **Exit 8** to Shady Grove Road headed west
Follow signs to the Hospital
Turn **right** onto Medical Center Way (at sign for Shady Grove Hospital)
Turn **right** at stop sign onto Medical Center Drive
Make **a U-turn** at 1st left and take 1st right into parking lot. There is a parking gate but parking is free.