

A d v a n c e d



S u r g e r y

GLENN L. SANDLER, M.D.

• CRAIG P. COLLIVER, M.D.

Dear Patient:

Your appointment is scheduled for _____.
____ Rockville Office: 9707 Medical Center Drive, Suite 320 Rockville, MD 20850

**** Please plan to arrive 20 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

9707 MEDICAL CENTER DRIVE, SUITE 320 * ROCKVILLE, MD * 20850

PHONE: (301) 251-4128 FAX: (301) 73 8-1593

www.advancedsurgery.net



ADVANCED SURGERY, PC

GLENN SANDLER MD AND CRAIG COLLIVER MD

Today's Date:	(Please Print)	For office Use: GS <input type="checkbox"/> CC <input type="checkbox"/>
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PATIENT INFORMATION

Primary Care Physician or Group:		Referring Physician:	
First Name:	MI:	Last Name:	Preferred Name:
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Sr. <input type="checkbox"/> Jr. <input type="checkbox"/> III			
Street address:		City:	County:
Street address 2:		State:	ZIP Code:
Home no.: ()		Cell no.: ()	
		Birth date:	
		Age:	
Work no.: ()		Email: @	
		Social Security #:	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F		Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered <input type="checkbox"/>	
Race: <input type="checkbox"/> Black <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Hispanic <input type="checkbox"/> Indian <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other <input type="checkbox"/> Oriental/Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Caucasian			
Occupation:		Employer:	
		Status: FT <input type="checkbox"/> PT <input type="checkbox"/> Ret <input type="checkbox"/> Tmp <input type="checkbox"/> Other: <input type="checkbox"/>	
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)		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> 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:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other
					Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Subscribers Place of Employment:			Tel Number:		

Secondary Insurance Information

Secondary Insurance Name		Telephone #:		<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> 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:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other
					Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Subscribers Place of Employment:			Tel Number:		

WHO ARE WE AUTHORIZED TO COMMUNICATE WITH ON YOUR BEHALF?

Name of person(s) to call in case of emergency, receive medical info, make or change appointments, receive results, etc.	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 and Dr. Craig Colliver
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.)	<input type="checkbox"/> M	<input type="checkbox"/> F	DOB:	Age:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				
Primary Care Physicians:		Referring Physicians:		

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)

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

Health History Questionnaire (Continued)

Name: _____

Date: _____

PAST SURGICAL HISTORY (Please check all that apply)

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

<input type="checkbox"/> Bladder cancer _____ <input type="checkbox"/> Breast cancer _____ <input type="checkbox"/> Colon cancer _____ <input type="checkbox"/> Crohn's disease _____ <input type="checkbox"/> Gastric cancer _____ <input type="checkbox"/> Head and Neck cancer _____ <input type="checkbox"/> Kidney cancer _____ <input type="checkbox"/> Liver cancer _____ <input type="checkbox"/> Lung cancer _____ <input type="checkbox"/> Lymphoma _____	<input type="checkbox"/> Melanoma _____ <input type="checkbox"/> Ovarian cancer _____ <input type="checkbox"/> Pancreatic cancer _____ <input type="checkbox"/> Prostate cancer _____ <input type="checkbox"/> Reaction to anesthesia _____ <input type="checkbox"/> Stomach cancer _____ <input type="checkbox"/> Thyroid cancer _____ <input type="checkbox"/> Ulcerative colitis _____ <input type="checkbox"/> Uterine cancer _____ <input type="checkbox"/> Other _____
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Social History (Please check each column)

Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered	Employment status: <input type="checkbox"/> Employed <input type="checkbox"/> Not employed <input type="checkbox"/> Self employed <input type="checkbox"/> Stay at home mom <input type="checkbox"/> Retired <input type="checkbox"/> Student	Tobacco (choose one) <input type="checkbox"/> Current every day smoker <input type="checkbox"/> Current some day smoker <input type="checkbox"/> Cigarettes Amount___ pks/day <input type="checkbox"/> Cigars Amount___ #/week <input type="checkbox"/> Chew Amount___ #/day <input type="checkbox"/> Former smoker: Year quit _____ <input type="checkbox"/> Never smoker	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> 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:	Skin	Nervous System	
<input type="checkbox"/> No Complaints of this type	<input type="checkbox"/> No Complaints of this type	<input type="checkbox"/> No Complaints of this type	
<input type="checkbox"/> Fever	<input type="checkbox"/> Rash	<input type="checkbox"/> Difficulty with Memory	<input type="checkbox"/> Headaches
<input type="checkbox"/> Chills	<input type="checkbox"/> Itching	<input type="checkbox"/> Difficulty with Speech	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Sweats	<input type="checkbox"/> Dryness	<input type="checkbox"/> Difficulty Walking	
<input type="checkbox"/> Lack of Appetite	<input type="checkbox"/> Yellowing Skin	<input type="checkbox"/> Fainting	
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Changes in Hair	<input type="checkbox"/> Paralysis	
<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Changes in Nails	<input type="checkbox"/> Numbness	
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Changes in Moles/Lesions	<input type="checkbox"/> Seizures	
<input type="checkbox"/> Unable to sleep	<input type="checkbox"/> New Skin Lesions	<input type="checkbox"/> Tremors	
<input type="checkbox"/> Weakness			
Cardiac	Breathing	Hematologic	
<input type="checkbox"/> No Complaints of this type	<input type="checkbox"/> No Complaints of this type	<input type="checkbox"/> No Complaints of this type	
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Cough	<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Heart Racing	<input type="checkbox"/> Shortness of Breath in general	<input type="checkbox"/> Bleed Easily	
<input type="checkbox"/> Shortness of Breath while lying down	<input type="checkbox"/> Coughing up Blood	<input type="checkbox"/> Blood Clots	
<input type="checkbox"/> Shortness of Breath with exertion	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Enlarged Lymph Nodes	
<input type="checkbox"/> Swelling in legs	<input type="checkbox"/> Painful Breathing	<input type="checkbox"/> Bleeding Gums	
Gastrointestinal	Genitourinary		Psychological
<input type="checkbox"/> No Complaints of this type			<input type="checkbox"/> No complaints of this type
<input type="checkbox"/> Painful Swallowing			<input type="checkbox"/> Depression
<input type="checkbox"/> Heartburn			<input type="checkbox"/> Anxiety
<input type="checkbox"/> Abdominal Pain			<input type="checkbox"/> Hallucinations
<input type="checkbox"/> Nausea			<input type="checkbox"/> Paranoia
<input type="checkbox"/> Vomiting			<input type="checkbox"/> Phobias
<input type="checkbox"/> Vomiting Blood			
<input type="checkbox"/> Diarrhea			
<input type="checkbox"/> Constipation			
<input type="checkbox"/> Black Stools			
<input type="checkbox"/> Bloody Stools			
<input type="checkbox"/> Gas/Bloating			
<input type="checkbox"/> Change in Bowel Habit			
<input type="checkbox"/> Difficulty Swallowing			
<input type="checkbox"/> Yellow eyes or skin			
	Men	Women	
	<input type="checkbox"/> No Complaints of this type	<input type="checkbox"/> No Complaints of this type	
	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Vaginal Discharge	
	<input type="checkbox"/> Bloody Urine	<input type="checkbox"/> Urine leakage	
	<input type="checkbox"/> Penile Discharge	<input type="checkbox"/> Painful Urination	
	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Bloody Urine	
	<input type="checkbox"/> Hesitancy in Urination	<input type="checkbox"/> Frequent Urination	
	<input type="checkbox"/> Frequent Night Urination	<input type="checkbox"/> Abnormal Vaginal Bleeding	
	<input type="checkbox"/> Urine Leakage	<input type="checkbox"/> Pelvic Pain	
	<input type="checkbox"/> Erectile Dysfunction		

Health History Questionnaire
(Continued)

Name: _____ Date: _____

Please check off all that apply for each body system

Vascular	Muscular/Skeletal	Endocrine
<input type="checkbox"/> No Complaints of this type	<input type="checkbox"/> No Complaints of this type	<input type="checkbox"/> No Complaints of this type
<input type="checkbox"/> Blue Fingers/Toes	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Intolerance to Cold
<input type="checkbox"/> Swelling in Extremities	<input type="checkbox"/> Joint Swelling	<input type="checkbox"/> Intolerance to Heat
<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/> Pain in Legs with Walking	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Excessive Hunger
<input type="checkbox"/> Resting leg Pain	<input type="checkbox"/> Muscle Shrinkage	<input type="checkbox"/> Excessive Urination
	<input type="checkbox"/> 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 and Craig P. Colliver are owners of Surgery Center of Rockville, L.L.C.
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 Surgery Center of Rockville, L.L.C.
3. You will not be treated differently by your physician if you choose to obtain health care services at a facility other than Surgery Center of Rockville, L.L.C.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of Surgery Center of Rockville, L.L.C. 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 Surgery Center of Rockville, L.L.C.

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: _____



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 portions ***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 or Dr. Colliver. ***This does not included 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 facilities. If you have any questions, please contact those facilities 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.

Deductibles/Co-Insurances for Office Visits:

Advanced Surgery requires you to pay any in-network or out of network deductibles, co-pays and/or co-insurance portions at the time of your office visit.

Updated 7/9/2009

a d v a n c e d



GLENN L. SANDLER, MD • CRAIG P. COLLIVER, MD

Directions

Rockville

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

9707 Medical Center Drive, Suite 320, 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 your first **left** into our parking lot (Sona Bank building)

9707 MEDICAL CENTER DRIVE, SUITE 320 • ROCKVILLE, MD • 20850

PHONE: (301) 251-4128 FAX: (301) 738-1593

WWW.ADVANCEDSURGERY.NET