Appointment Information:

Patient: _____

Date: _____

Time: _____

Aaron G. Margulies MD
Compassionate surgical care you can trust

North Office Location	West Office Location	Jefferson City Location
7714 Conner Road Suite 107 Knoxville, TN 37849	Tennova Turkey Creek Medical Center 10810 Parkside Drive Suite G-11 Knoxville, TN 37934	Jefferson Memorial 120 Hospital Drive Suite G-50 Jefferson City, TN 37760

Thank you for choosing our office for your surgical consultation. To assist us in providing you with the best care possible, please bring the following with you to your appointment:

- ✓ Insurance cards and Photo ID
- ✓ Medication list including dosages
- ✓ Complete the attached forms

We value your time and want to provide you with a comprehensive and in-depth evaluation. To do so, please allow up to two hours in our office for your appointment. If you have any questions prior to your scheduled appointment, please contact our office at **865-692-1610**. For more information, you can go to our website, **www.aaronmd.com** and/or complete the digital form on our website by scanning the QR code below.

If your insurance has been purchased through the Affordable Healthcare Marketplace, please verify with your carrier that Dr. Margulies is an "in-network provider" by calling the number on the back of your insurance card.

We look forward to meeting you and providing you with compassionate surgical care that you can trust.

Sincerely,

Aaron G. Margulies, MD
Aaron G. Margulies, MD, FACS
Breast Surgical Oncologist / General Surgeon

Patient Demographic & Consent Form

First Name: _____ Middle Initial_____ Last Name: _____

DOB: _____/_____/_____ SS#: _____-_____-_____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Numbers

Home: (_____) _____

Mobile: (_____) _____

Work: (_____) _____

Occupation: _____

Preferred Method of Contact: (Circle One)

Home Mobile Work

Marital Status: _____

Email: _____@_____

Employer: _____

Emergency Contacts

1. _____ Relation: _____ Phone: _____

2. _____ Relation: _____ Phone: _____

Do you consent for our office to leave a voice message if needed? **Yes No**

May we contact and share medical information with your emergency contacts if needed? **Yes No**

Would you like an email for sign-up information to Dr. Margulies' blog on Breast Cancer? **Yes No**

Would you like an email invite to register an account on our patient portal? **Yes No**

Which Office is most convenient for you? (Circle One) **Powell Turkey Creek Jefferson City**

How did you hear about our practice? _____

If you are a **Breast Care Patient**, do you give consent for Dr. Margulies to discuss your case with other physicians? **Yes No**

If you are a **Genetics Patient**, do you give consent for our office to release or obtain copies of your genetic testing? **Yes No**

Insurance ***If your insurance carrier through your spouse or someone else please complete the following:**

Name of Insured: _____ DOB: _____ SS#: _____-_____-_____

Treating Physicians: Primary Care Physician: _____ Referring Physician: _____

Medical Oncologist: _____ Radiation Oncologist: _____

Gynecologists: _____

Pharmacy: Name: _____ City: _____ Phone: _____

By signing below, I verify that all the information above is correct. I also verify that I have been offered and have reviewed a copy of the Patient Privacy Notice required by HIPAA and understand my right to privacy as a medical patient of Aaron G. Margulies MD, PLLC.

Patient / Responsible Party Signature: _____ Date: _____

Aaron G. Margulies, MD, PLLC

Aaron G. Margulies, MD, FACS

Imelda G. Margulies, MSN, FNP-BC

FINANCIAL RESPONSIBILITY FORM

At the office of **Aaron G. Margulies, MD, PLLC**, we strive to give you the best possible care. In order to serve this purpose, it is important that our patients understand the process of reimbursement. Please read this Financial Responsibility Form and sign to acknowledge that you understand your accountability.

INSURANCE COVERAGE

It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations, as well as, authorization requirements. This information can be obtained by contacting your insurance carrier.

We attempt to verify that your coverage is valid at the time of your visit. However, if your coverage is not in effect at the time of the visit, the financial responsibility for any payment due will be yours.

***If you have any changes in your insurance coverage you must notify us prior to your appointment.**

DEDUCTIBLES, COINSURANCE AND COPAYMENTS

The deductible is determined by your individual contract with your insurance carrier. You are responsible for your deductibles, copayments, and coinsurance. Your insurance company expects us to collect them from you at the time of service. Understand that you will be expected to pay deductibles, coinsurance and copayments, when this applies.

NON-COVERED SERVICES AND MEDICAL NECESSITY

All patients are responsible for account balances if their insurance carrier denies payment for services rendered because they were stated as “non-covered services” or deemed as “medically unnecessary.” To avoid this, please check with your insurance carrier prior to receiving any treatment or services.

By signing below, I authorize the release of any medical information necessary to process insurance claims filed to my insurance carrier on my behalf or on the behalf of my dependents. I authorize payment for medical benefits to be made directly to my physician for services rendered at the office of **Aaron G. Margulies, MD, PLLC**.

I certify that I have read the above disclosure statements, understand my responsibilities, and agree to the terms written above.

Patient / Responsible Party Signature _____Date_____

Patient / Responsible Party Name (Please Print) _____

Relation to Patient: _____

Surgical Intake Questionnaire

Name: _____ Date of Birth: _____

Reason for Visit: (give a brief description)

Allergies & Medical History

Medical History / Problems: (list any medical problems that other doctors have diagnosed.)

History of Sleep Apnea: YES / NO CPAP: YES / NO Oxygen: YES / NO

Past Surgeries:

Daily Medications and Supplements:

Medication Allergies:

Do you have a family history of heart attacks, bleeding, or malignant hyperthermia? YES NO

Have you been vaccinated for COVID-19 YES NO

Social History

Height: Weight: Marital Status:

Employment Status: Occupation: Employer:

Tobacco Use: ☐ CURRENTLY ☐ IN THE PAST ☐ NEVER
If Tobacco use, do you smoke cigarettes, chew tobacco, or use pipes or cigars? _____
Number per day: _____
How many years have you used tobacco? _____

Alcohol Use: ☐ Yes ☐ No
If yes, how many drinks per week? _____