

Procedure Questionnaire

THIS QUESTIONNAIRE IS PART OF THE APPLICATION, INCLUDING A RENEWAL APPLICATION, SUBMITTED BY OR ON BEHALF OF THE APPLICANT FOR THE PROPOSED INSURANCE. THE NOTICES, CONDITIONS, REPRESENTATIONS AND AUTHORIZATIONS CONTAINED IN SUCH APPLICATION ARE INCORPORATED INTO AND APPLY TO THIS QUESTIONNAIRE.

For each procedure below, please provide the approximate number of times you have "Performed" or "Assisted" during the past 12 months as well as how many times you anticipate doing so during the next 12 months. If you Perform or Assist in other procedures not listed below, add each one under "Other" in each section.

	# Performed		# Assisted			# Performed		# Assisted	
	Past Year	Next Year	Past Year	Next Year		Past Year	Next Year	Past Year	Next Year
A. General Procedures:					B. Gynecology Procedures				
Alternative/Holistic Medicine (explain): _____					Abortions – Your Patients				
Angiography					1 st Trimester				
Angioplasty					After 12 weeks				
Anti-Aging Medicine (explain): _____					Therapeutic				
Arterial Catheterization					Elective				
Arteriography					Abortions – Other Patients				
Bronchoscopy					1 st trimester				
CCU Care (other than admitting)					After 12 weeks				
Chelation Therapy (explain): _____					Therapeutic				
Chemotherapy					Elective				
Colonoscopy					Attach list of facilities where you perform abortions.				
Cardiac Catheterization					A&P Repair				
Cardiac Cath – Right Heart Only					Cervical Cautery				
Cryosurgery (explain): _____					Cold Conization Cervix				
Dialysis Procedures					Culdocentesis				
Elective Cardioversion					Dilation & Curettage				
Endoscopy (explain): _____					Ectopic Pregnancy				
Hair Transplants					Hysterectomy – Vaginal				
Hypnosis					Hysterectomy – Abdominal				
IVP					Insertion of IUD				
Laser Therapy (explain): _____					In Vitro Fertilization				
Lymphangiography					If "Yes," % of practice: _____				
Myelography					Laparoscopy				
Paracentesis or Thoracentesis					Office Gynecology				
Polypectomy by Endoscopy					Oophorectomy or Salpingectomy				
Venography					Tubal Ligation				
Weight reduction or Weight Control					Other (describe): _____				
If "Yes," % of practice: _____									
List methods, drugs prescribed on a separate sheet of paper					Do you own or operate a sperm bank for				
Other (describe): _____					the treatment of your patients? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> None of the above					the treatment of others' patients? <input type="checkbox"/> Yes <input type="checkbox"/> No				
					<input type="checkbox"/> None of the above				

C. Pediatric Procedures	# Performed		# Assisted		D. Obstetrical Procedures	# Performed		# Assisted		
	Past Year	Next Year	Past Year	Next Year		Past Year	Next Year	Past Year	Next Year	
Circumcisions					Amniocentesis – 3 rd Trimester Only Amniocentesis – 1 st or 2 nd Trimester Breech Delivery Cesarean Sections Episiotomy Low Forceps Managing Toxemia Mid Forceps Normal Deliveries Prenatal Care Home Deliveries Other Non-Hospital Deliveries (explain): _____ VBAC Other (describe): _____					
Neonatology										
If "Yes," % of practice: _____										
Umbilical Catheterization & Monitoring										
Other (describe): _____										
<input type="checkbox"/> None of the above										
E. Surgical Procedures	# Performed		# Assisted			F. Urological Procedures Any cutting into or on the kidney, ureter or bladder Aspiration of Hydrocele Circumcisions Orchiectomy Phalloplasty (including transecting the suspensory ligament of the penis and/or subcutaneous fat injection) Prosthetic Implants Sex Change Surgery Treatment of Torsion of the Testicle Vasectomy Other (describe): _____ <input type="checkbox"/> None of the above	# Performed		# Assisted	
	Past Year	Next Year	Past Year	Next Year			Past Year	Next Year	Past Year	Next Year
Adenoidectomy										
Anal Fissure										
Anal Fistulectomies										
Any surgical procedure involving cutting into or within the abdominal cavity, chest cavity, orbital cavity, spine or facial sinuses										
Any surgical procedures on malignant lesions except for diagnostic purposes										
Amputations										
Appendectomies										
Aspiration of Cyst of Breast										
BCIR										
Biopsies If "Yes," explain types: _____										
Cholecystectomies – Open										
Chymopapian Injections										
Hemorrhoidectomies										
Hernioplasties										
Herniorrhaphy (Inguinal or Femoral Only)										
Laparoscopic Cholecystectomies										
Mastectomy										
Mastoidectomy										
Minor Office Surgery										
Myringotomy										
Nasal Polypectomy										
Operations within the middle or inner ear										
Organ Transplants If "Yes," explain: _____										
Otorhinolaryngology										
Peripheral Nerve Surgery										
Prostatectomy										
Reconstructive Vascular Surgery, Thromboembolism and/or Thrombectomy of the arteries or veins										
Repair of laceration not involving nerve or tendon										
Submucous Nasal Resections										
Surgical treatment of cysts, superficial abscesses, minor traumatic wound & superficial biopsies										
Surgical Weight Reduction										
Thyroidectomy										
Tonsillectomy										
Vein Stripping										
Other (describe): _____										
<input type="checkbox"/> None of the above										
					G. Anesthesia Procedures:	# Performed		# Assisted		
						Past Year	Next Year	Past Year	Next Year	
					Acupuncture					
					If "Yes," for anesthesia?					
					Caudal					
					Digital Block					
					General					
					Intravenous Anesthesia					
					Intravenous Analgesia					
					Nitrous Oxide					
					Obstetrical Anesthesia					
					Pain Blocks					
					Pain Management					
					If "Yes," please complete a Pain Management Questionnaire					
					Peripheral Nerve Block					
					Spinal Anesthesia					
					Other (describe): _____					
					If "Yes" for any Anesthesia type, check locations where performed: <input type="checkbox"/> Hospital <input type="checkbox"/> Surgicenter <input type="checkbox"/> Non-hospital facility					

H. Plastic & Cosmetic Procedures:	# Performed		# Assisted		Do you perform Anesthesia for any Bariatric Surgery Procedures? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Past Year	Next Year	Past Year	Next Year		
Autologous Fat Injection					Do you employ any inhalation therapists? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Blepharoplasty (cosmetic)					Have you assumed supervisory duties over: Nurse Anesthetists? <input type="checkbox"/> Yes <input type="checkbox"/> No Inhalation Therapists? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Botox Injections						
If "Yes," location, by whom and what procedure/purpose? _____					<input type="checkbox"/> None of the above	
Breast Reduction					I. Orthopedic & Neurosurgical Procedures:	
Breast Enhancement – Silicone						# Performed
Breast Enhancement – Saline						Past Year
Breast Enhancement – Trans-Umbilical						Next Year
Chemical Peels						# Assisted
Collagen Injections						Past Year
Coronal Lift						Next Year
Dermabrasion						Any operative orthopedics
Hair transplants or suturing of hair pieces						Arthroscopy or Arthrography
Injection Treatment of Varicose Veins						Injection of Bursa
Laser Therapy (explain): _____						Joint Implants
Laser vaginal rejuvenation (includes cosmetic and /or plastic surgery procedures performed on the vagina and associated structures. This includes, but is not limited to vaginoplasty, labiaplasty, laser and non-laser rejuvenation procedures).						Neuro Implant Surgery for Pain
Other Surgical Procedures (explain): _____						Open Reduction of Fractures
Liposuction – under 3500 ccs						Prolotherapy
Liposuction - 3500 ccs or more						If "Yes," do you use Phenol? <input type="checkbox"/> Yes <input type="checkbox"/> No
Phalloplasty – including transecting the suspensory ligament of the penis and/or subcutaneous fat injection					Repair of Extensor Tendon	
Rhinoplasty					Repair of Flexor Tendon	
Silicone Implants (types and where) _____					Spinal Surgery	
_____					Anterior Cervical Discectomies	
_____					Cervical Laminectomies	
_____					Pedicle Screw	
_____					Scoliosis Surgery	
_____					Stereotactic Neurosurgery	
_____					Other (describe): _____	
_____					<input type="checkbox"/> None of the above	
_____					J. Ophthalmology Procedures:	
Silicone Injections						# Performed
Other (describe): _____						Past Year
<input type="checkbox"/> None of the above						Next Year
						# Assisted
						Past Year
						Next Year
						Automated Lamellar Keratotomy
						Blepharoplasty (Cosmetic)
						Blepharoplasty (Functional)
						Cataract Surgery
						Chalazion Excision from Eyelids
						Corneal Transplants
						Enucleation
						Hexagonal Keratotomy (HK)
					Intraocular Lens Implant	
					Iridectomy	
					LASIK	
					Lid-Repair – Ectropion & Entropion	
					Photo-Refractive Keratotomy (PRK)	
					Pterygium Excision	
					Refraction's	
					If "Yes," what type? _____	
					Removal of Eyelid Lesion	
					Retinal Detachments	
					Trabeculectomy	
					Treatment of Eye Infection	
					Other (describe): _____	
					<input type="checkbox"/> None of the above	

SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this questionnaire are true and complete.

The notices, conditions, representations and authorizations contained in the Application submitted by or on behalf of the Applicant for the proposed insurance, are incorporated into and apply to this questionnaire.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	