



The Plastic Surgery Group

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Mr./Mrs./Miss/Ms./Dr. _____
First Name Middle Last Name Nickname (if used)

Male Female STATUS: Single Married Divorced Widow

Street Address City/State Zip Code

(_____) _____ (_____) _____ (_____) _____
Home Telephone Number Business Telephone Number Cellular Telephone Number

_____/_____/_____ _____/_____/_____ _____
Social Security Number Date of Birth Age

Please initial here to allow us to contact you by e-mail _____
Email Address

Employed By Street Address City/State Zip Code

REASON FOR VISIT: _____ REFERRED BY: _____

Insurance Info: Worker's Compensation Motor Vehicle Accident Other _____

Name of Insurance Company Subscriber Name Subscriber SS # Subscriber DOB

ACKNOWLEDGEMENT: I hereby acknowledge that in consideration for treatment rendered to me and/or my child or child in my care that I am responsible and will pay for all charges and fees of the doctors of The Plastic Surgery Group for the services rendered. I understand that although I may have insurance to cover the cost of treatment, I remain responsible for payment. All payments are due within thirty (30) days of receipt of the bill.

Signature (Patient or Responsible Party) Date

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS: I hereby authorize the doctors of The Plastic Surgery Group to release any information acquired in the course of my examination or treatment and further authorize payment of the surgical and/or medical benefits directly to the physicians.

Signature (Patient or Responsible Party) Date

AUTHORIZATION TO PHOTOGRAPH: I hereby grant authority to the doctors of The Plastic Surgery Group to take pre and post operative photographs for insurance documentation or internal use only.

Signature (Patient or Responsible Party) Date

The Plastic Surgery Group

Height _____ Weight _____

ALLERGIES: List all)

Medications	Type of Reaction	Food	Type of Reaction	Environmental	Type of Reaction

MEDICATIONS: (include aspirin, hormone replacement, birth control, diet pills, sleep aids, all vitamins, herbs, teas, over-the-counter or alternative therapies)

Medication (name of drug)	Dosage (how much)	Frequency (how often)

PAST MEDICAL HISTORY: Do you have now or have you had in the past any of the following:

	YES	NO		YES	NO
Bleeding	___	___	Asthma	___	___
Chronic Cough	___	___	Heart Disease	___	___
High Blood Pressure	___	___	Tuberculosis	___	___
Jaundice	___	___	GI disease	___	___
Hepatitis	___	___	Fever Blisters	___	___
Neurological disease	___	___	Lung Disease	___	___
Steroid use	___	___	Convulsions	___	___
Kidney disease	___	___	History of Blood Clots	___	___
Diabetes	___	___	Family History of Blood Clots	___	___
Rheumatic Fever	___	___	Psychiatric/emotional disorder	___	___
Heavy Scars	___	___	Motion Sickness	___	___

LIST OTHER MEDICAL CONDITIONS: _____

If "yes" to any of the above, please provide details. _____

PAST SURGERIES/HOSPITALIZATIONS:

Date	Type of Surgery	Name of Hospital	Doctor

ANESTHESIA HISTORY:

Have you ever had a **REACTION** to a **GENERAL** anesthetic? (Being put to sleep) Yes No
 Has a family member ever had a **REACTION** to a **GENERAL** anesthetic? Yes No
 Have you ever had a **REACTION** to a **LOCAL** anesthetic? (Novocain, etc.) Yes No

If "yes" to any of the above, please provide details. _____

SOCIAL HISTORY

Tobacco (cigarettes, cigars, pipe) [list amount/day and # of years smoking]

If you ever smoked but don't now, when did you quit?

Have you been exposed to heavy second hand cigarette, cigar or pipe smoke for an extended period of time on a regular basis in the past two years? Yes No

Recreational drugs (type of drug and number of years of use) _____

Alcohol (type, how often) _____

FAMILY HISTORY (list relationship, age, medical problem and if they are living or deceased)

Mother	Father	Sisters	Brothers

Primary Care MD

Pharmacy

 Name & telephone #

 Name & telephone #

Emergency contact person:

 Name & telephone #

PATIENT /GUARDIAN SIGNATURE: _____

RELATIONSHIP OF GUARDIAN TO PATIENT: _____

The Plastic Surgery Group does not participate in any insurance plan.

In order to clarify our office policy, we ask that you read and sign the following explanation.

Thank you.

The Plastic Surgery Group has advised me that they do not participate with any insurance carrier. I understand that this means they don't accept my insurance as payment in full.

I understand that I am responsible for any charges incurred and will be balance billed for all co-payments, non-covered charges over U&C and deductibles.

X _____ Date: _____
Patient/Guardian's signature

X _____ Date: _____
Please print patient's name

**ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices for
THE PLASTIC SURGERY GROUP.

Print Patient Name: _____

Signature of Patient: _____

Date: _____

***If person signing is not the patient, please print your name and relationship to patient:**

Name _____

Relationship _____

I (patient or representative) request a copy of the Notice of Privacy Practices:

Yes _____ No _____

For office use:

If patient /representative requested copy of Notice, date copy was provided:

_____.

If no acknowledgment could be obtained, state the reasons why and the efforts taken to try to obtain the acknowledgment.

