

**THE PLASTIC SURGERY GROUP, P.A.**

Mr./Mrs./Miss/Ms. \_\_\_\_\_  
First Name Middle Last Name Nickname (if used)

Male  Female STATUS:  Single  Married  Divorced  Widow

HOW WOULD YOU LIKE TO BE ADDRESSED? Circle one: Mr. Mrs. Miss. Ms. Other: \_\_\_\_\_

Street Address City/State Zip Code

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

/ / / / / /  
Social Security Number Date of Birth Age E-mail address

Please initial here \_\_\_\_\_ to allow us to contact you by e-mail.

Employed By Street Address City/State Zip Code

Motor Vehicle Accident  Worker's Compensation  Other \_\_\_\_\_

Subscriber of Policy Relationship Date of Birth Social Security Number

REASON FOR VISIT: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

**\*\*PLEASE PRESENT ALL INSURANCE CARDS TO RECEPTIONIST\*\*  
IF YOU HAVE A SECONDARY INSURANCE PLEASE ADVISE US**

I understand that a fee is charged for all first visits, examinations, cosmetic evaluations and medical reports. Fees for cosmetic surgery are payable in advance.

**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 or have taken any photographs of the patient whose name appears above which may be necessary.

\_\_\_\_\_  
Signature (Patient or Responsible Party) Date

**The Plastic Surgery Group – medical/surgical history**

Name: \_\_\_\_\_ Date \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

**ALLERGIES:** (if yes, please list medication and type of reaction) \_\_\_\_\_

\_\_\_\_\_

**MEDICATIONS** (list prescribing doctor; include hormone replacement, diet pills, 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	_____	_____	Diabetes	_____
Rheumatic Fever	_____	_____	Asthma	_____
Cough	_____	_____	Heart Disease	_____
High B/P	_____	_____	Tuberculosis	_____
Jaundice/Hepatitis	_____	_____	GI disease	_____
Neurologic disease	_____	_____	Lung Disease	_____
Steroid use	_____	_____	Convulsions	_____
Kidney disease	_____	_____		

**LIST OTHER MEDICAL CONDITIONS** \_\_\_\_\_

**HAVE YOU EVER BEEN HOSPITALIZED FOR A MEDICAL CONDITION?** (for what and when) \_\_\_\_\_

\_\_\_\_\_

**PAST SURGERIES** (list type of surgery, hospital, physician and date/year)

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Have you ever had a <u>REACTION</u> to a GENERAL anesthetic? (being put to sleep)	Yes	No
Have you ever had a <u>REACTION</u> to a LOCAL anesthetic? (Novocain, etc.)	Yes	No
Do you form heavy scars?	Yes	No
Do you have frequent infections or boils?	Yes	No
Have you ever had any significant emotional problems?	Yes	No
Have you ever been advised or had psychiatric care?	Yes	No
Have you seen other plastic surgeons about the SAME problem that brings you here?	Yes	No

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

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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

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

**Recreational drugs** (type of drug and number of years of use) \_\_\_\_\_

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**Alcohol** (type, how often) \_\_\_\_\_

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

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**Primary Care MD**

**Pharmacy**

Name & telephone #

Name & telephone #

**Emergency contact person**

Name & telephone #

SIGNATURE \_\_\_\_\_

RELATIONSHIP TO PATIENT (self, parent) \_\_\_\_\_

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.

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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 \_\_\_\_\_

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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.

\_\_\_\_\_  
\_\_\_\_\_  
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