Plastic Surgery Specialists

Patient Name: ______________________ **Social Security #** ____________

Date of Birth: ____________ Age: ______ Sex: **M F** Marital Status: **S M D W**

Cell Phone: ______________ Home Phone: ______________
Home Address: ______________ City: ________ State: ________ Zip: ______
Occupation: ______________ Employer: ______________ Work Phone: ______________

Spouse's Name: ____________ Occupation: ____________ Employer: ____________ Work Phone: ____________

Emergency Contact: ______________ **Relationship:** ____________ **Phone:** ____________

Physician Referral: Dr. ______________________
How did you hear about us? ☐ Internet ☐ About Town Magazine ☐ Phone Book Other ____________
Family Member/Friend: ______________
Preferred Method of Contact: ☐ Phone: ______________ ☐ Email: ______________

Responsible Party / Guarantor Information

Name of **Responsible Party:** ______________ Home Phone: ____________ Cell Phone: ____________
Home Address: ______________ City: ________ State: ________ Zip: ________
Occupation: ______________ Employer: ______________ Work Phone: ______________
Relationship to Patient: ______________

Insurance Information

Name of **Primary** Insurance: ______________
Contract #: ______________
Group/Policy#: ______________
Guarantor Name: ______________
Date of Birth (Guarantor): ______________

Name of **Secondary** Insurance: ______________
Contract #: ______________
Group/Policy#: ______________
Guarantor Name: ______________
Date of Birth (Guarantor): ______________

Patient Contact Information

Any Physician, Staff, Employee or Representative of Plastic Surgery Specialists has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications, or any other types of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment:

Name & Relationship:	Date of Birth:	Phone #

If your insurance company requires photocopies, then copies of your photos may be required to be sent to your health insurer for consideration of insurance coverage for the desired procedure(s). This is for procedures that require photo proof for pre-authorization approval for a procedure. I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record, to obtain pre-authorizations for a procedure and/or for before and after photos for a procedure. By consenting to these medical photographs I understand that I will not receive payment from any party. If I have any questions or wish to withdraw my consent in the future I may contact Plastic Surgery Specialists, P.C.
***** When used in this manner, photos are edited to remove all identifying marks or features where applicable. *****

I hereby authorize Plastic Surgery Specialists to release any information acquired in my examination or treatment to any insurer, government agency providing benefits, or to anyone for charges. I also, hereby, assign to and authorize payment to Plastic Surgery Specialists of all benefits payable under the terms of any insurance policy listed. I realize the insurance, workman's compensation, and/or liability claims may not pay the entire bill, and I agree to pay the difference of the bill or the entire bill if necessary. In the event the account is not paid in full within 90 days I also agree to pay costs of collection, including attorney's fee and waive my exemption under the constitution and laws of the state of Alabama. I understand that it is my obligation to pay my co-payment at the time services are rendered (as stated in my signed contract with my insurance company). I understand that it is the policy of Plastic Surgery Specialists to collect all deductibles or outstanding account balances before surgical procedures or office visits will be performed. Plastic Surgery Specialists participates with the Worthless Check Unit of the City of Birmingham and does prosecute for bad checks written to our company. All court costs are the responsibility of the patient and/or check writer.

Signature below is only acknowledgement that you have received this HIPAA Notice of our Privacy Practices, consent for photocopies for insurance and surgical purposes, and consent for authorization for treatment:

Patient Name (Print): ______________ **Patient Signature:** ______________ **Date:** ________

Responsible Party Signature: ______________
(if patient is a minor)

History & Physical

Medications

1. ____________ 6. ____________
2. ____________ 7. ____________
3. ____________ 8. ____________
4. ____________ 9. ____________
5. ____________ 10. ____________

Allergies

1. ____________ 6. ____________
2. ____________ 7. ____________
3. ____________ 8. ____________
4. ____________ 9. ____________
5. ____________ 10. ____________

What is your current ____________ **Height**

____________ **Weight**

Smoking Status

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoked / none

Race

- ☐ White
- ☐ Black / African American
- ☐ American Indian / Alaskan Native
- ☐ Native Hawaiian / Pacific Islander
- ☐ Unspecified
- ☐ Other Race: ____________________

Do you have a family history of Melanoma? _____ Yes _____ No

Do you have a family history or Breast Cancer? _____ Yes _____ No

Do you have any relatives, who have had an allergic reaction to anesthesia, or death related to anesthesia or surgery? _____ Yes _____ No

Past Medical History

Select any of the following medical conditions that you currently have:

- ☐ Anemia/Thalassemia
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bipolar Disorder
- ☐ Blood Clotting Disorder
- ☐ Breast Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep Venous Thrombosis
- ☐ Diabetes
- ☐ Easy Bruising
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Neuromuscular Disorder
- ☐ Pulmonary Embolism
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Severe Reaction to Anesthesia
- ☐ Pacemaker/Defibrillator
- ☐ Valvular Heart Disease
- ☐ Stroke
- ☐ Other ____________________ ____________________ ____________________
- ☐ None

Past Surgeries

Have you had any previous surgery (surgeries)?

Type of Procedure: ____ Year: ____________

Type of Procedure: ____ Year: ____________

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Type of Procedure: ____ Year: ____________