PLASTIC SURGERY ASSOCIATES

Dependent Patient Information Form- *please print*

Patient Name _____ Date of Birth _____age_____

Address _____ Home phone# _____

City _____ State _____Zip _____ Social Security #_____

Primary Care Physician_____Phone#_____Gender M F

Mother's Name_____Date of Birth_____age_____

Address *(if different)*_____Phone#_____

Driver's License#_____Social Security #_____

Mother's Employer_____Occupation_____Phone#_____

Father's Name_____Date of Birth_____age_____

Address *(if different)*_____Phone#_____

Driver's License#_____Social Security #_____

Father's Employer_____Occupation_____Phone#_____

How did you hear about our office? _____

Please indicate if there is anything we need to know to provide you more personal care_____

_____

YOU WILL NEED TO PRESENT YOUR INSURANCE CARD AT THE TIME OF YOUR APPOINTMENT

Is this a Worker's Compensation or Auto Accident? Yes No

Insurance Company _____claim#_____

Address_____phone#_____

ASSIGNMENT OF BENEFITS, INSURANCE BILLING AUTHORIZATION, RECORDS RELEASE

I, the patient's parent/guardian realize that I am responsible for paying deductibles, copays, any non-covered services, and/or any services disputed by our insurance company, as well as any collection fees. My insurance company may provide an estimate of what services they will cover, and my provider will use this estimate in good faith to provide an estimate of what my out-of-pocket expenses will be. If my insurance company does not cover any portion for any reason, or decreases the amount after the fact, I will be responsible for these fees or whatever difference is they do not pay. By signing this document, I acknowledge understanding and agree to the terms of this policy and am consenting to financial liability for these fees. I authorize payment to be made on my behalf to Plastic Surgery Associates for any services provided to the family member I am the guardian of, by my provider. I agree that I will pay any remaining balance no later than 30 days following the insurance payment. I understand that any outside laboratory fees and pathology fees are billed directly to me and are not part of my fees quoted to me by Plastic Surgery Associates. I authorize Plastic Surgery Associates to release any medical information necessary to pay my claim and understand if a cosmetic and medical procedure is being done, my insurance company may receive medical records pertaining to both services. I hereby authorize the release of pertinent medical information necessary to process my claim, which may include mental, physical, cosmetic, medical, prescription, substance abuse, communicable diseases, and infections, HIV-related, AIDS, or AIDS related information. I further authorize release of the described pertinent information to other medical providers involved in my care.

_____ _____

(patient/parent/guardian signature) *(date)*

☐ **I Have Received a Copy of the Notice of Privacy Practices at Plastic Surgery Associates, patient rights and responsibilities, and the disclosure of ownership.**

PLASTIC SURGERY
ASSOCIATES

acct# _____

What is your main concern(s) for today's discussion?_____

If injury, what was the date of the injury?_____Were X-Rays taken? *Yes No* Where?_____

Have you consulted any other physician for this problem? No Yes- who?_____

Do you have an advanced directive?_____yes _____no If no, you can find information at www.michigan.gov/mdhhs.

*If **YES**, please bring a copy with you on the day of surgery.

_____

Allergies/reaction: _____

Medications(prescription): name, dose, frequency, reason

_____

_____

_____

_____

Over the Counter(herbal supplements/vitamins):

_____

_____

_____

_____

Surgeries/Hospitalizations:

_____date_____

_____date_____

_____date_____

_____date_____

Anesthesia History:

Have you had anesthesia? Yes No
Nausea/Vomiting after? Yes No
Motion Sickness? Yes No
Malignant Hyperthermia?
(self or family) Yes No

Female patients:

Number of Pregnancies _____
Number of Children _____
Most Recent Mammogram_____
Location of Mammogram_____

Social History:

(please indicate daily consumption):
Alcohol_____
Tobacco or Tobacco Products_____
Other intoxicating substances_____

Height_____ How much weight have you ***lost*** in the past year? _____

Weight_____ How much weight have you ***gained*** in the past year? _____

Past Medical History

	yes	no		yes	no		yes	no
Eye Injury			Heart Disease			Diabetes		
Eye Disease			Heart Attack			Thyroid Disorder		
Dry Eye			High Blood Pressure			Numbness of hands/feet		
Impaired Vision			Blood Clots			MRSA		
Blackouts			Bleeding Tendency			TB		
Seizures			Rheumatic Fever			Hepatitis		
Concussion/Head Injury			Cancer			AIDS/HIV		
Facial Nerve Injury			Asthma			AutoImmune Disease		
Wide Scars			Chronic Cough			Gonorrhea		
Keloids			Respiratory Problems			Syphilis		
Gastric Surgery			Pneumonia			Mental Illness		
			Sleep Apnea			Depression/Anxiety		

I realize that accurate medical information is essential for safe and proper medical care. The above information is true and accurate to my best knowledge.

_____ _____

(patient signature) (date)