account#_____

PLASTIC SURGERY ASSOCIATES

Patient Information Form- *please print*

Patient Name _____ Date of Birth _____age_____

Address _____ Home phone# _____

City _____ State _____Zip _____ Cell Phone# _____

Email address _____ Marital status M S W D Gender M F

Primary Language_____ Driver's License#_____ Social Security#_____

Employer_____ Occupation_____ Full Time/ Part Time

Address_____

Business Phone# _____May we contact you at work? Yes No

Spouse's Name_____Date of Birth_____Social Security#_____

Employer_____ Employer's Phone#_____

Next of Kin/ Emergency Contact _____Phone#_____

Primary Care Physician_____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 realize I am responsible for paying deductibles, copays, any non-covered services, and/or any services disputed by my insurance company, as well as any collection fees. My insurance company may provide an estimate of what they will cover, and my provider will use this estimate in good faith to provide me 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 me 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 my provider to release any medical information necessary to pay my claim, and I understand if I am having both a cosmetic and medical procedure, 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)*

_____ _____

Witness 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

Previous issues with intubation during anesthesia? 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? _____

In the last 3 months, have you been exposed to lice, fleas or bed bugs? Yes or No

If Yes, what treatment did you use and when? _____

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)