PATIENT INFORMATION FORM

Today's Date: _____

Name: _____ **DOB:** _____ **Age:** _____

Home Phone: _____ **Work:** _____ **Cell:** _____

Address: _____ **Cell Carrier:** ☐ **AT&T** ☐ **Verizon** **Other:** _____

City: _____ **State:** _____ **Zip:** _____

Email: _____

How did you hear about us? ☐ Patient Referral: _____

☐ Dr. Referral: _____ ☐ Web Search Search Term:_____

☐ Practice Website ☐ Facebook ☐ Other: _____

What is the nature of your visit?

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Primary Insurance

Insurance Name: _____ Policy #: _____ Group ID: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Policy Holder: _____ Policy Holder Date of Birth: _____

Secondary Insurance

Insurance Name: _____ Policy #: _____ Group ID: _____

Assignment and Release

I, _____, have insurance coverage and assign directly all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured / Guardian Date

Consent to Communicate

Method	Preferred	OK to leave Voicemail?	OK to speak with Another Person?
☐ Call Work Phone	☐	☐Yes ☐No	☐Yes ☐No
☐ Call Cell Phone	☐	☐Yes ☐No	☐Yes ☐No
☐ Call Home Phone	☐	☐Yes ☐No	☐Yes ☐No
☐ Email Appt Reminders	☐	☐ Email Medical Info	☐ Email Marketing Info
☐ Text Appt Reminders	☐	☐ Text Marketing Info	☐ Send Regular Mail

Consent to Communicate

Name	DOB	Relationship	OK to Release Results?
			☐Yes ☐No

_____ _____

Signature Date

Section I: Medications & Allergies

1. Reason for your visit? _____

2. Are you taking any medications, vitamins or herbal supplements? ☐ No ☐ Yes, please list: _____

3. Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list: _____

Section II: Specific Medical History

1. Are you pregnant? ☐ No ☐ Yes Height: _____ Weight: _____

	Have **you** or do you still have:	**No**	**Yes**	**No**	**Yes**	Have any **blood relatives** had: **Relation?**
2.	Asthma	☐	☐	☐	☐	
3.	Emphysema	☐	☐	☐	☐	
4.	High Blood Pressure	☐	☐	☐	☐	
5.	Heart Trouble	☐	☐	☐	☐	
6.	Hepatitis or Liver Trouble	☐	☐	☐	☐	
7.	Kidney Trouble	☐	☐	☐	☐	
8.	Diabetes	☐	☐	☐	☐	
9.	Epilepsy or Seizures	☐	☐	☐	☐	
10.	Stroke	☐	☐	☐	☐	
11.	Problem Scarring	☐	☐	☐	☐	
12.	Bleeding Tendency	☐	☐	☐	☐	
13.	Psychiatric Care	☐	☐	☐	☐	
14.	Severe Allergies	☐	☐	☐	☐	
15.	Repeated Infections	☐	☐	☐	☐	
16.	Arthritis	☐	☐	☐	☐	
17.	Cancer	☐	☐	☐	☐	
18.	Migraines	☐	☐	☐	☐	
19.	Others Not Listed:					

Section III: Social History

1. Do you smoke? ☐ No ☐ Yes, how much? _____ 2. Do you drink? ☐ No ☐ Yes, how much?

3. Do you have children? ☐ No ☐ Yes, how many? _____ _____

Section IV: Surgical History

List previous surgeries:

Any Anesthesia Complications? No ☐ Yes ☐, describe:

Bleeding Disorders? No ☐ Yes ☐, describe:

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: _____ Date: _____

HIPAA Information and Consent

Patient Name: _____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____

Photography Information and Consent

I, _____, give consent that Beachwood Plastic Surgery can photograph or film me but only to the extent necessary, and so long as the images are used solely for purposes of (a) identifying me as a patient or for purposes of diagnosis and treatment and documenting my health status; (b) conducting education and training, quality assurance and performance improvement functions for and on behalf of Beachwood Plastic Surgery and its professional staff.

Additionally, I give written consent for use of my photographs or film for one or more of the following purposes listed.

_____ Use or disclosure of image for use on practice website(s)
_____ Use or disclosure of image for print or digital marketing & advertising purposes
_____ Use or disclosure of image in a professional presentation or journal publication

_____ _____
Patient (or Patient's Legal Representative) Signature Date