WESTERN MARYLAND HEALTH SYSTEM
Caring for What Matters Most ©

WMHS PLASTIC SURGERY
Emme Jackson, MD

Western Maryland Medical Arts Center, 12502 Willowbrook Road, Suite 450 · Cumberland, MD · 21502 · (240) 964-8931 MR#_____

Patient Name: Last First Middle

Date of Birth / / Age Sex ☐ Male ☐ Female

Social Security Number (SS #)

Street Address

City State Zip

Email Address

Would you like to receive emails regarding periodic special offers and news from our practice? ☐ Yes ☐ No

Home Phone Mobile Work

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Race ☐ American Indian ☐ Asian ☐ African American ☐ Caucasian ☐ Unreported/Refused to Report ☐ Undefined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unreported ☐ Refused to Report ☐ Undefined

Language Preference

Employer

Spouse's Name DOB / / SS #

Spouse's Employer Work Phone

Emergency Contact Relationship

Emergency Contact Number

DISCLOSURE OF PROTECTED HEALTH INFORMATION

According to office policy, test results or release of medical information including, but not limited to, appointment times, lab or test results, etc., will be provided to the patient only. Please specify below whom information may be released to other than yourself.

I grant permission for WMHS Plastic Surgery to release any and all of my medical information to the person(s) listed below.

Patient Signature:_____

Name Relationship Name Relationship

Name Relationship Name Relationship

May we leave messages at your: ☐ Home Answering Machine ☐ Cell Phone ☐ Work Voice Mail ☐ Email

FINANCIAL INFORMATION

Person Responsible for Payment Relationship to Patient

Street Address (if different from above)

City State Zip

Home Phone Mobile Work

IF THE PATIENT IS A MINOR/STUDENT

Father's Name/Legal Guardian

Address (if different from patient)

City State Zip

SS # DOB / /

Home/Cell # Work#

Employer

Mother's Name/Legal Guardian

Address (if different from patient)

City State Zip

SS # DOB / /

Home/Cell # Work#

Employer

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PLEASE COMPLETE ALL SECTIONS

Primary Insurance Name Subscriber's Name

Relationship to Patient DOB / / SS#

Secondary Insurance Name Subscriber's Name

Relationship to Patient DOB / / SS#

Eligible for coverage under Workers' Compensation/Job Related? ☐ Yes ☐ No

Is your injury/illness due to an accident? ☐ Yes ☐ No ☐ Automobile ☐ Other (describe below)

Date of accident/injury / / State where accident/injury occurred:

COMPLETE THIS SECTION IF YOU ARE COVERED UNDER MEDICARE

Medicare law requires that we determine if your medical services might be covered by another insurer. In order to assist us in the correct billing of these services, please answer the following questions.

Are you employed? ☐ Yes ☐ No

If retired, list date of retirement / /

Please list employer information on front of form.

Please complete health plan information on front of form.

Is your spouse employed? ☐ Yes ☐ No

If retired, list date of retirement / /

Please list employer information on front of form.

Please complete health plan information on front of form.

ADVANCED DIRECTIVES

Do you have a Living Will or Durable Power of Attorney? ☐ Yes ☐ No

Please provide WMHS Plastic Surgery with a copy of your file. WMHS Plastic Surgery does not honor Advanced Directives/Living Wills and our policy is as follows: Regardless of any advanced directive, if an adverse event occurs during your treatment at this office, we will initiate resuscitative or other stabilizing measures and transfer you to the nearest hospital for further evaluation. At the hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or Health Care Power of Attorney. Your agreement with this policy by your signature does not revoke or invalidate any current health care power of attorney.

AUTHORIZATION

I authorize WMHS Plastic Surgery to release to my insurance company, managed care organization, state agency(ies), federal agency(ies), Centers for Medicare & Medicaid Services, Third Party Administrators, and/or Workers Compensation or its agents any information needed to process my claim and/or determine benefits payable for related services. I also authorize WMHS Plastic Surgery to utilize a fax machine or secure email to transmit any or all of the above medical records pertaining to my medical care or insurance reimbursement. I acknowledge that faxing or secure emailing of my medical records may increase the risk of accidental disclosure of my medical records. I grant permission to WMHS Plastic Surgery to release all or part of my medical records to any consulting entity that may be involved in my medical care. This includes, but is not limited to, testing facilities, consulting physicians and outpatient facilities. I request that payment of Medicare, Third Party Administrators for services furnished to me or on my behalf by that provider.

I understand that I am financially responsible for deductible amounts, co-payments, co-insurance amounts, non-covered charges and any and all balances not covered under a contractual write-off agreement between WMHS Plastic Surgery and my third party payer. My carrier's failure to pay does not release me from this responsibility. I also agree that should this account be turned to collection, I will be responsible for all costs associated with debt collection, including attorney fees and court costs.

Signature of Patient or Responsible Party/Insured Date

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Emme Jackson, MD

Office Use Only
Dr. #_____
Acct. #_____
B/P_____/_____ T_____P_____R_____
Height _____Weight _____

MR#_____

Date_____

Patient Name _____ _____
Last First Middle Date of Birth Age

Referred By Primary Care Doctor

Reason for appointment

If applicable: date of injury or onset of problem

Is this the result of a work or car accident? ☐ Yes ☐ No

What makes the problem/pain worse or better?

Past Medical History

Have you ever been a patient in this office? ☐ Yes ☐ No

IF ADDITIONAL SPACE IS NEEDED IN ANY SECTION OF THIS FORM ATTACH A SEPARATE SHEET

List any current medical problems you have.

Medical Problem	Medical Problem

Allergies: List medications and/or foods that you are allergic to and what kind of reaction you have.

Medication/Food	Reaction	Medication/Food	Reaction

Family History: Any family history of medical problems? If so, please list.

Type of Problem	Family Member	Type of Problem	Family Member

Social History

Student: ☐ Yes ☐ No Grade Level_____ ☐ Full time ☐ Part time

Occupation Employer How Long?

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Use of Alcohol ☐ Never ☐ Rarely ☐ Moderate (2 drinks/day) ☐ Heavy (more than 2 drinks/day)

Tobacco Use ☐ Never ☐ Smoker _____Packs/day ☐ Previous Smoker: Date quit___/___/___ ☐ Chew Tobacco ☐ Use Snuff

If you have children ages 0-17 list their ages

Present Medications: Prescriptions or non-prescription

Name of Medication	Dosage/Frequency	Name of Medication	Dosage/Frequency

Have you ever had any problem with anesthesia? ☐ Yes ☐ No If yes, explain. _____

Surgical/Hospitalization History

Type of Surgery or Hospitalization	Date	Type of Surgery or Hospitalization	Date

DO YOU CURRENTLY HAVE, OR HAVE YOU EVER HAD A PROBLEM WITH:

Breast
- ☐ Breast Discharge
- ☐ Breast Pain
- ☐ Cancer
- ☐ Fibrocystic Disease
- ☐ Lump in Breast

Genitourinary
- ☐ Hematuria
- ☐ Incontinence
- ☐ Kidney Disease
- ☐ Urinary Frequency
- ☐ Urinary Tract Infections
- ☐ Urinary Tract Problem

Psychiatric
- ☐ ADD
- ☐ ADHD
- ☐ Alcohol Abuse
- ☐ Alzheimer's
- ☐ Anxiety Disorder
- ☐ Bipolar Disease
- ☐ Confusion
- ☐ Depression
- ☐ Drug Dependency
- ☐ Insomnia
- ☐ Memory Loss
- ☐ Nervousness
- ☐ Other

Cancer
- ☐ Brain
- ☐ Breast
- ☐ Cervical
- ☐ Colon
- ☐ Ovarian
- ☐ Prostate
- ☐ Rectal
- ☐ Skin
- ☐ Stomach
- ☐ Throat
- ☐ Thyroid

HEENT
- ☐ Allergic Rhinitis
- ☐ Blurred/Double Vision
- ☐ Cataracts
- ☐ Chronic Sinusitis
- ☐ Ear Drainage
- ☐ Ear Infections
- ☐ Earache
- ☐ Eye Disease
- ☐ Eye Injury
- ☐ Glaucoma
- ☐ Head Injury
- ☐ Hearing Loss
- ☐ Mouth Sores
- ☐ Nasal Polyps
- ☐ Nose Bleeds
- ☐ Ringing in Ears
- ☐ Glasses/Contacts

Cardiac
- ☐ Angina Pectoris
- ☐ Chest Pain
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hypertension (High Blood Pressure)
- ☐ Hypotension (Low Blood Pressure)
- ☐ Irregular Heartbeat
- ☐ Mitral Valve Prolapse
- ☐ Swelling of Feet, Ankles or Hands
- ☐ High Cholesterol

Congenital
- ☐ Cleft Lip
- ☐ Cleft Palate
- ☐ Facial Deformity
- ☐ Hand Deformity
- ☐ Skull Deformity

Hematology
- ☐ Abnormal bleeding in your family
- ☐ Anemia
- ☐ Bleeding or Bruising Tendency
- ☐ Clotting Disorder
- ☐ Deep Venous Blood Clots
- ☐ Known HIV/AIDS Exposure
- ☐ Phlebitis
- ☐ Slow to heal after cuts
- ☐ Transfusion History

Respiratory
- ☐ Asthma
- ☐ Chronic or Frequent Cough
- ☐ COPD
- ☐ Emphysema of Lung
- ☐ Pneumonia
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Tuberculosis

Endocrine
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Glandular Hormone
- ☐ Heat or Cold Intolerant
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

Musculoskeletal
- ☐ Arthritis
- ☐ Back Injury
- ☐ Back Pain
- ☐ Cold Extremities
- ☐ Difficulty Walking
- ☐ Fibromyalgia
- ☐ Joint Injury
- ☐ Joint Pain
- ☐ Joint Problems
- ☐ Joint Stiffness/Swelling
- ☐ Low Back Pain
- ☐ Muscle Pain/Cramps
- ☐ Neck Pain
- ☐ Osteoporosis
- ☐ Weakness
- ☐ Weakness of muscles or joints

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Colon Polyps
- ☐ Duodenal Ulcer
- ☐ Gastric Ulcer
- ☐ GERD
- ☐ Heartburn
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ Liver Disease
- ☐ Nausea & Vomiting
- ☐ Ulcerative Colitis

Neurologic
- ☐ Head Injury
- ☐ Migraine Headache
- ☐ Numbness & Tingling
- ☐ Parkinson's Disease
- ☐ Restless Leg Syndrome
- ☐ Seizure Disorder
- ☐ Stroke
- ☐ Transient Ischemic Attack
- ☐ Tremors

Skin
- ☐ Change in Skin
- ☐ Rash or Itching
- ☐ Varicose Veins

PRESCRIPTION REFILL POLICY

Refills for Prescription Medications need to be called in to our office between 8:30 am and 4:00 pm Monday through Friday. All approved prescriptions will be called into the pharmacy by the end of that business day. Prescriptions should be taken "AS DIRECTED." Early refills may be denied. No medications will be refilled after hours or on weekends.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature _____ Date _____

I have reviewed the above information with the patient.

Physician Signature _____ Date _____