



Patient Name: Last			First			Middle		
Date of Birth / /			Age			Sex <input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Home Phone			Mobile			Work		
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed								
Race <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Unreported/Refused to Report <input type="checkbox"/> Undefined								
Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unreported <input type="checkbox"/> Refused to Report <input type="checkbox"/> 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 _____
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Name _____	Relationship _____	Name _____	Relationship _____
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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			Mother's Name/Legal Guardian		
Address (if different from patient)					
City		State		Zip	
SS #		DOB / /		DOB / /	
Home/Cell #		Work#		Work#	
Employer			Employer		



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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No
If retired, list date of retirement / /	If retired, list date of retirement / /
Please list employer information on front of form.	Please list employer information on front of form.
Please complete health plan 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 _____



Office Use Only

Dr. # _____

MR# _____

Acct. # _____

B/P _____ / _____ T _____ P _____ R _____

Date _____

Height _____ Weight _____

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

Drug Use Never Yes Type: _____

Dominant hand Left Right 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:

<p>Breast</p> <input type="checkbox"/> Breast Discharge <input type="checkbox"/> Breast Pain <input type="checkbox"/> Cancer <input type="checkbox"/> Fibrocystic Disease <input type="checkbox"/> Lump in Breast	<p>Cancer</p> <input type="checkbox"/> Brain <input type="checkbox"/> Breast <input type="checkbox"/> Cervical <input type="checkbox"/> Colon <input type="checkbox"/> Ovarian <input type="checkbox"/> Prostate <input type="checkbox"/> Rectal <input type="checkbox"/> Skin <input type="checkbox"/> Stomach <input type="checkbox"/> Throat <input type="checkbox"/> Thyroid	<p>Cardiac</p> <input type="checkbox"/> Angina Pectoris <input type="checkbox"/> Chest Pain <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension (High Blood Pressure) <input type="checkbox"/> Hypotension (Low Blood Pressure) <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Swelling of Feet, Ankles or Hands <input type="checkbox"/> High Cholesterol	<p>Hematology</p> <input type="checkbox"/> Abnormal bleeding in your family <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding or Bruising Tendency <input type="checkbox"/> Clotting Disorder <input type="checkbox"/> Deep Venous Blood Clots <input type="checkbox"/> Known HIV/AIDS Exposure <input type="checkbox"/> Phlebitis <input type="checkbox"/> Slow to heal after cuts <input type="checkbox"/> Transfusion History	<p>Endocrine</p> <input type="checkbox"/> Diabetes Type I <input type="checkbox"/> Diabetes Type II <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Excessive Urination <input type="checkbox"/> Glandular Hormone <input type="checkbox"/> Heat or Cold Intolerant <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypothyroidism	<p>Gastrointestinal</p> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Colon Polyps <input type="checkbox"/> Duodenal Ulcer <input type="checkbox"/> Gastric Ulcer <input type="checkbox"/> GERD <input type="checkbox"/> Heartburn <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> Liver Disease <input type="checkbox"/> Nausea & Vomiting <input type="checkbox"/> Ulcerative Colitis	
<p>Genitourinary</p> <input type="checkbox"/> Hematuria <input type="checkbox"/> Incontinence <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Urinary Frequency <input type="checkbox"/> Urinary Tract Infections <input type="checkbox"/> Urinary Tract Problem	<p>HEENT</p> <input type="checkbox"/> Allergic Rhinitis <input type="checkbox"/> Blurred/Double Vision <input type="checkbox"/> Cataracts <input type="checkbox"/> Chronic Sinusitis <input type="checkbox"/> Ear Drainage <input type="checkbox"/> Ear Infections <input type="checkbox"/> Earache <input type="checkbox"/> Eye Disease <input type="checkbox"/> Eye Injury <input type="checkbox"/> Glaucoma <input type="checkbox"/> Head Injury <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Mouth Sores <input type="checkbox"/> Nasal Polyps <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Glasses/Contacts	<p>Congenital</p> <input type="checkbox"/> Cleft Lip <input type="checkbox"/> Cleft Palate <input type="checkbox"/> Facial Deformity <input type="checkbox"/> Hand Deformity <input type="checkbox"/> Skull Deformity	<p>Respiratory</p> <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic or Frequent Cough <input type="checkbox"/> COPD <input type="checkbox"/> Emphysema of Lung <input type="checkbox"/> Pneumonia <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Tuberculosis	<p>Musculoskeletal</p> <input type="checkbox"/> Arthritis <input type="checkbox"/> Back Injury <input type="checkbox"/> Back Pain <input type="checkbox"/> Cold Extremities <input type="checkbox"/> Difficulty Walking <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Joint Injury <input type="checkbox"/> Joint Pain <input type="checkbox"/> Joint Problems <input type="checkbox"/> Joint Stiffness/Swelling <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Muscle Pain/Cramps <input type="checkbox"/> Neck Pain <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Weakness <input type="checkbox"/> Weakness of muscles or joints	<p>Neurologic</p> <input type="checkbox"/> Head Injury <input type="checkbox"/> Migraine Headache <input type="checkbox"/> Numbness & Tingling <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Restless Leg Syndrome <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Stroke <input type="checkbox"/> Transient Ischemic Attack <input type="checkbox"/> Tremors	
<p>Psychiatric</p> <input type="checkbox"/> ADD <input type="checkbox"/> ADHD <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Bipolar Disease <input type="checkbox"/> Confusion <input type="checkbox"/> Depression <input type="checkbox"/> Drug Dependency <input type="checkbox"/> Insomnia <input type="checkbox"/> Memory Loss <input type="checkbox"/> Nervousness <input type="checkbox"/> Other						<p>Skin</p> <input type="checkbox"/> Change in Skin <input type="checkbox"/> Rash or Itching <input type="checkbox"/> 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