

PATIENT INFORMATION

DATE: _____

Name: (Full Legal): First _____ Middle Initial _____ Last _____

Preferred or Nickname: _____ Gender: M F Other Date of Birth: _____ Age: _____

Race: Check all that apply White Asian Black or African American Native Hawaiian /Other Pacific Islander American Indian/Alaska NativeMarital Status Single Married Partner Widowed Divorced OtherEthnicity: Not Hispanic/Not Latino Hispanic or LatinoPreferred or Primary Language: (please check box) English Other specify language: _____

Address: Street _____ Apt/Unit # _____

City _____ State _____ Zip _____

Please indicate your primary/preferred phone number to reach you .

This should be a number where we can leave a DETAILED MESSAGE.Primary or Preferred Phone Number: () _____ Home Work Cell Other _____

Alternative Phone numbers

Other phone numbers: () _____ Home Work Cell Other _____Other phone numbers: () _____ Home Work Cell Other _____

Email address: (required for patient portal) _____

Do you want to be registered for our patient portal to access your health information: Yes NoCommunication preference: Phone Mail Messages via patient portal (requires email address and registration for portal)If the patient is a **minor or has a legal guardian**, please provide the responsible party's information below:

Responsible Party Name: _____ Relationship to patient: _____

 Address same as above

Address: Street _____ Apt/Unit# _____ Date of Birth: _____

City _____ State _____ Zip _____

Phone Number: () _____ Home Work Cell Other _____

Emergency Contact Information

Name: _____ Relationship to patient: _____

Contact phone numbers: () _____ Alternate Number: () _____

Preferred Pharmacy Information

Store Name: _____ Phone #: () _____

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

Please complete additional information and signatures on the back of this form.

If you are being seen for a **worker's compensation injury** or some other type of liability claim (example: **auto or home accident**) please see the receptionist for an additional form and do not complete the back of this form.

INSURANCE INFORMATION

The receptionist will also make a copy of your insurance card/s. The insurance subscriber information is not provided on your identification card and is needed to file your claims to your insurance company.

Primary Insurance Company Name: _____

Insurance Subscriber Name: _____ Birthdate: _____

Patient Relationship to the insurance subscriber: _____

Secondary Insurance Company Name: _____

Insurance Subscriber Name: _____ Birthdate: _____

Patient Relationship to the insurance subscriber: _____

ASSIGNMENT OF BENEFITS and INSURANCE INFORMATION RELEASE

I authorize payment of medical benefits to Midwest Plastic Surgery for services rendered to myself or dependents. I authorize Midwest Plastic Surgery to release on behalf of myself or my dependents any information required or requested by my insurance carrier or other reimbursement entities for the purpose of payment. I understand that I am responsible for any amount my insurance company indicates as patient responsibility.

Signature: _____ **Date:** _____

RELEASE OF INFORMATION for treatment

I authorize Midwest Plastic Surgery to release on behalf of myself or my dependents any information required for treatment to my health care providers or other medical entities involved in my care. I also authorize Midwest Plastic Surgery to release limited health information to other entities for legitimate business activities such as patient experience surveys.

Signature: _____ **Date:** _____

RELEASE OF INFORMATION for marketing purposes

I authorize Midwest Plastic Surgery to use my documented demographic information to contact myself or dependents with marketing information, materials, or offers for the practice and physicians.

Signature: _____ **Date:** _____

MEDICATION HISTORY

I authorize Midwest Plastic Surgery to review any medication history that may be available through an electronic prescription database.

Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Midwest Plastic Surgery's **HIPAA Notice of Privacy Practices** is available for you to review. It is presented with this form in the office. Please request a copy of the notice from the receptionist or download it from our website (www.midwestplasticsurgery.net) if you complete this form in advance.

I acknowledge that I have been offered the HIPAA Notice of Privacy Practices for Midwest Plastic Surgery.

Signature: _____ **Date:** _____

Relationship to Patient: _____

HEALTH HISTORY QUESTIONNAIRE

DATE: _____

PATIENTS NAME _____ PREFERRED NAME _____

AGE _____ (if minor, who is completing form) _____

OCCUPATION _____

REFERRING DOCTOR/SOURCE _____

PRIMARY CARE PHYSICIAN _____

REASON FOR BEING SEEN TODAY _____

Circle the conditions that you have/had

Asthma/COPD	Diabetes	Depression	Breast cancer
Sleep Apnea / CPAP	High blood pressure	Anxiety / Bipolar	HIV / AIDS
Heart disease / Heart attack	Kidney dialysis	Seizure disorder	Stroke
Lasik eye surgery	Hypothyroidism	Chemotherapy	Skin cancer
Atrial Fibrillation	Blood clots	Radiation therapy	Herpes / cold sores
Pacemaker / defibrillator	Hepatitis	High cholesterol	Reflux / ulcers

For the following questions please use the back of this sheet if you need additional space

Please list any other medical problems that you have:

Please list any of the above conditions which have affected your family members:

Please list all previous surgeries (including cosmetic surgeries):

List all medications you are taking, include prescription and over the counter or herbal medications:

Do you take aspirin, ibuprofen, steroids/cortisone/prednisone, Coumadin or blood thinners:

List any allergies or sensitivities and reaction (include medication, food, latex, anesthesia related problems, etc.):

Circle your answers below

Do you use alcohol? YES / NO
Do you use caffeine? YES / NO
Do you use recreation drugs? YES / NO

Smoking History (circle your answer)

Never smoker
Former smoker
Current some day smoker ___ amount
Current every day smoker ___ amount

Women only:

Are you pregnant or trying to conceive? YES / NO
Number of pregnancies: _____
Have you had a mammogram? YES / NO If yes date of most recent mammogram _____

OFFICE USE

HEIGHT _____ WEIGHT _____ BP _____