Plastic Surgery Specialists

112 Abingdon Place, Abingdon, Virginia 24211 Phone: (276) 623-4500

Patient Name:_____ Today's Date:_____

Street Address:_____
Home Address City State Zip

Mailing Address: _____
Home Address City State Zip

Home Phone: (_____)_____Work Phone: (_____) _____

Cell Phone: (_____)_____ E-Mail Address:_____

What Phone Numbers May We Use To Leave You A Message (check all that apply): [ ] Home [ ] Work [ ] Cell

Date of Birth: _____Social Security Number:_____

Sex: [ ] Female [ ] Male Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Employer:_____Occupation:_____

Employer Address:_____
Street Address City State Zip

RESPONSIBLE PARTY INFORMATION (If Different From Patient Information):

Name:_____ Relationship: _____ DOB: _____

Address: _____
Street Address City State Zip

Home Phone: (_____) _____ Work Phone: (_____)_____

Employer: _____

INSURANCE INFORMATION:

Subscriber Name:_____

Subscriber Birth Date: _____ Subscriber Social Security Number: _____

MISCELLANEOUS:

Patient Was Referred By (Name of Physician, Friend, Phone Book, Newspaper, Internet, etc.): _____

If Phone Book, Newspaper, Radio, TV or Internet - Which Publication, Station or Site? _____

Name of Primary Care Doctor: _____

Reason For Visit: _____

INSURANCE RELEASE:

I give my consent for Plastic Surgery Specialists, P.C. to supply information from my medical records to my insurance carriers, Medicare, Medicaid or other third parties to allow them to make appropriate payment. Plastic Surgery Specialists will bill my insurance for a period of 90 days. If after 90 days, the insurance carrier has not paid, I will be responsible for making monthly payments as deemed appropriate by the practice until my insurance pays. I understand that I am financially responsible for all charges whether or not they are paid by my insurance company. I authorize the use of this signature for all insurance submissions. I understand that if I fail to show up for a regularly scheduled appointment, I will be charged a missed appointment fee. I further understand that the penalties for cancelling surgical procedures are greater than this and are outlined in the materials provided to me at the time that I was given my pricing quote. Should I not make payment as required, then I shall be additionally liable for all collection expenses, court costs, reasonable attorney fees of 25% of the amount owed and interest thereon at the rate of six percent (6%) per annum from the date of service. I understand that I am responsible for obtaining a referral authorization from my primary physician as is appropriate for treatment. I understand that if I write a check with insufficient funds, I will be charged a penalty of $35. I have read and understand the 'signature on file.'

_____ _____
Signature of Patient or Parent If Minor Date

RECEIPT OF HIPAA PRIVACY RULES:

I have read and understand the 'HIPAA Privacy Rules

_____ _____
Signature of Patient or Parent If Minor Date

HEALTH HISTORY:

Height: _____ Weight: _____

Please List Any Prescription or Non-Prescription Drugs You Are Now Taking (Please Include Herbal Products) – *If None, Please State None*:

_____

_____

_____

Please Check Any Allergies To The Medicines Listed Below *(If Checked, What Type Reaction)*:

[ ] Penicillin_____ [ ] Sulfa Drugs_____ [ ] Novocaine_____ [ ] Codeine_____ [ ] Tetanus_____

[ ] Aspirin_____ [ ] Morphine_____ [ ] Xylocaine_____ [ ] Iodine_____ [ ] **No Known Allergies**

[ ] Latex_____ Other_____

Please Check If You Have Had Or Now Have Any of the Following Conditions:

[ ] Heart Disease	[ ] Mitral Valve Prolapse	[ ] Anesthesia Problems	[ ] Migraine Headaches	[ ] Keloids
[ ] Hypothyroidism	[ ] Arthritis	[ ] Depression	[ ] Stroke	[ ] Substance Abuse
[ ] Hyperthyroidism	[ ] Cancer _____	[ ] High Blood Pressure	[ ] Psychiatric Illness	[ ] Seizure Disorder
[ ] Sexually Transmitted Disease	[ ] Stomach Ulcer	[ ] Diabetes	[ ] Rheumatic Fever	[ ] Sleep Apnea
[ ] Asthma	[ ] Hepatitis	[ ] Anemia	[ ] Glaucoma	[ ] _____
[ ] Respiratory Problems	[ ] Bleeding Tendency	[ ] Kidney Disease	[ ] Tuberculosis	[ ] **No Known Problems**

Please Check If Any Blood Relative Ever Had Any of the Following:

[ ] Breast Cancer	[ ] High Blood Pressure	[ ] Kidney Disease	[ ] Melanoma	[ ] Heart Disease
[ ] Depression	[ ] Stroke	[ ] Diabetes	[ ] Malignant Hyperthermia	[ ] **No Known Problems**

Review of Systems - Do You Have Now or Have You Had Within the Past Year:

[ ] Weight Change	[ ] Swollen Feet/Ankles	[ ] Seizures	[ ] Dry Eyes	[ ] Skin Rash
[ ] Joint or Muscle Pain	[ ] Chronic Cough	[ ] Chronic Diarrhea	[ ] Swollen Lymph Nodes	[ ] Chest Pain
[ ] Jaundice	[ ] Easy Bleeding	[ ] Rapid Heart Beat	[ ] Depression	[ ] **No Known Problems**
[ ] Easy Bruising				

Please List Any Surgical Procedures, Endoscopies or Hospital Admissions With Date: *(If None, Please State None)*_____

_____

Do You Drink Alcoholic Beverages: [ ] No [ ] Yes - Social _____ Moderate_____ Heavy _____

Smoke/Use Tobacco: [ ] No [ ] Yes - Packs Per Day_____ [ ] Quit - When _____

For Patients Under 18:

Child Immunizations Are Up To Date: [ ] Yes [ ] No

For Women Only:

Age Period Began:_____ Date of Last Mammogram: _____

Number of Pregnancies: _____ Number of Children: _____

Date of Last Pap Smear: _____

BLOOD TESTING CONSENT:

Since 1993, the Commonwealth of Virginia has required that if an employee at physician's office is exposed to body fluids from a patient in a manner that might transmit Hepatitis B, Hepatitis C or Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immunodeficiency Syndrome (AIDS), that the patient will be tested for these diseases. If such a test is necessary you will be informed of the blood test and you will be given the opportunity to ask any questions at that time. By signing this release you have consented to such testing and consented to the release of the test results to the healthcare provider who was exposed.

I have read and understand the 'Blood Test Consent.'

_____ _____

Signature of Patient or Parent If Minor Date

FORM ACKNOWLEDGEMENT:

I verify that the information contained on this registration form is accurate to the best of my knowledge.

_____ _____

Signature of Patient or Parent If Minor Date