

**PATIENT INFORMATION**

Name \_\_\_\_\_ M F S \_\_\_\_\_ M \_\_\_\_\_ W \_\_\_\_\_ D \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone # (\_\_\_\_) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_ Cell Phone # (\_\_\_\_) \_\_\_\_\_  
Employer/Address \_\_\_\_\_  
How did you hear about our practice? \_\_\_\_\_ E-mail \_\_\_\_\_  
Family MD \_\_\_\_\_ Referring MD \_\_\_\_\_

**SPOUSE INFORMATION or (if patient is a child) PARENT INFORMATION**

Spouse Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_  
Spouse Employer/Address \_\_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_\_  
Father's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_  
Father's Occupation/Employer \_\_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_\_  
Mother's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_  
Mother's Occupation/Employer \_\_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_\_

**INSURANCE INFORMATION**

Is this visit related to a work injury or auto accident? Yes No Date of accident/injury \_\_\_\_/\_\_\_\_/\_\_\_\_  
Primary Insurance/Address \_\_\_\_\_  
Policy Holder \_\_\_\_\_ Patient ID# \_\_\_\_\_ Group # \_\_\_\_\_  
Secondary Insurance/Address \_\_\_\_\_  
Policy Holder \_\_\_\_\_ Patient ID# \_\_\_\_\_ Group # \_\_\_\_\_

**INSURANCE AUTHORIZATION AND ASSIGNMENT**

understand that I am responsible for any amount not covered by insurance. I understand that if I fail to furnish a required insurance referral from my primary physician (ex. CDPHP, MVP), I shall be responsible for payment in full for any charges related to this visit, for services provided to me or my dependent(s). All balances will be subject to interest after sixty (60) days. I hereby consent to give peer physician the authority to review my chart to obtain information about the delivery of medical care.

**Signature X** \_\_\_\_\_ **Date** \_\_\_\_\_

**Witnessed** \_\_\_\_\_ **Date** \_\_\_\_\_

# MEDICAL HISTORY

Name \_\_\_\_\_ Date \_\_\_\_\_

**1. LIST your allergies** \_\_\_\_\_

Are you allergic to: Latex? Yes No Coumadin? Yes No Local Anesthetics? Yes No

**2. LIST all your medications** \_\_\_\_\_

Do you take: Aspirin? Yes No Coumadin? Yes No Steroids? Yes No

Do you need antibiotics before dental work? Yes No

**3. CHECK all medical problems below that you have experienced:**

Seizures/ Stroke/ Fainting	High Blood Pressure	Bladder/ Kidney Problems
Vision Problems	Mitral Valve Prolapse	Poor Circulation
Dry Eyes	Breast Cancer / Cysts	Anemia
Eye Disease	Fibromyalgia	Excessive Bleeding (from cuts,surgery)
Sinus Infections	Thyroid Problems	Arthritis
Nasal Obstruction	Diabetes	Abnormal Scars, (i.e. keloids)
Shortness of Breath/Cough	Liver Disease/Hepatitis	Depression
Chest Pain/ Angina	Immune Disease (i.e.HIV)	Anxiety Reactions
Palpitations	Intestinal Problems	

Other \_\_\_\_\_

**4. LIST any previous surgical procedures** \_\_\_\_\_

Have you had a blood transfusion? Yes No

**5. LIST any problems with general anesthesia or sedatives** \_\_\_\_\_

**6. Do you have:** Dental Caps? Yes No Bridgework? Yes No Dentures? Yes No

Partial Plates? Yes No

**7. LIST your DAILY consumption of the following:**

Coffee/Tea \_\_\_\_\_ Alcohol \_\_\_\_\_ Tobacco \_\_\_\_\_ Street Drugs \_\_\_\_\_

**8. Is there a FAMILY history of:** (circle all that apply) Skin Cancer / Breast Cancer / Heart Disease / Diabetes

Other \_\_\_\_\_

**9. Please add any other pertinent history that may help us with your care:** \_\_\_\_\_

Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

**Relationship** (if other than self, ex. Parent) \_\_\_\_\_

## PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of an individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone \_\_\_\_\_

O.K. to leave message with detailed information

Leave message with call-back number only

Written Communication

O.K. to mail to my home address

O.K. to mail to my work/office address

O.K. to fax to this number

Work Telephone \_\_\_\_\_

O.K. to leave message with detailed information

Leave a message with call-back number only

Family or friends who we may discuss your care with: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Birth date

The privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses of disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly will constitute an adequate record.

***Note: Uses and disclosure for TPO may be permitted without prior consent in an emergency.***

### Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

- (1) Check this box if the disclosure was authorized
- (2) Type Key: T= Treatment Records; P=Payment Information; O=Healthcare Operations
- (3) Enter how disclosure was made; F=Fax; P=Phone; E=Email; M=Mail; O=Other

# Fox & Schingo Plastic Surgery

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (name of patient) \_\_\_\_\_ acknowledge and agree that I have received a copy of Fox & Schingo Plastic Surgery's Notice of Privacy Practices.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Legal Representative (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Legal Representative

\_\_\_\_\_  
Relationship to Patient

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### FOR CLINICAL USE ONLY:

Fox & Schingo Plastic Surgery made the following good faith efforts to obtain the above referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

*(Identify the efforts that were made to obtain the individual's written acknowledgment, including the reasons why the written acknowledgment was not obtained)*

# **Fox & Schingo Plastic Surgery**

## **A NOTE TO PATIENTS CONCERNING POST-OPERATIVE VISITS:**

If you are having a surgical procedure in our office, please be advised that not all surgical procedures include post-operative visits, suture removals and/or scar evaluations at no charge to you. Each procedure performed has a specific number of follow-up days which are included in your surgery at no additional charge. These global days are determined by your insurance plan and CMS (The Centers for Medicare and Medicaid Services).

Please be advised that we do not schedule follow-up appointments based upon follow-up days- appointments are scheduled based upon medical necessity and schedule availability.

I acknowledge that I have read and understand the surgical global policy as indicated above and agree that I will be held responsible for balance due included co-insurance, deductible and/or co-payments.

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Patient Signature

Date Signed