

Date _____

TALLAHASSEE PLASTIC SURGERY

Hill _____ Harper _____

Paredes _____

Last Name Initial		First Name		Middle	Marital Status S M W D		Sex ____ Male ____ Female		Social Security #		
Date of Birth		Age	Race		Home Phone ()		Cell Phone ()		Work Phone ()		
Physical Address					City			State		Zip	
Mailing Address (if not same)					City			State		Zip	
Employer Name			Employer Address					Employer Phone #			
Referring Doctor			Family Doctor				Emergency Contact (Name and Phone #)				

GUARANTOR (FINANCIAL RESPONSIBILITY)

Name			Relationship		Date of Birth		Social Security			
Address							Phone # ()			
City					State			Zip Code		
Employer (Company Name)					Job Title or Retirement Date		Phone # ()			

INSURANCE INFORMATION

Primary Insurance			Phone # ()		ID #		Group #		
Policy Holder's Name				Date of Birth		Social Security #			
Authorization				Date		Authorized by			
Secondary Insurance			Phone # ()		ID #		Group #		
Policy Holder's Name			Date of Birth			Social Security #			

INFORMATION RELEASE

Physicians and staff of the Tallahassee Plastic Surgery Clinic consider all patient information confidential. List all individuals with whom we may discuss your medical condition, test results, and/or treatment plan. Please sign below indicating you have given this authorization.

YOU MAY DISCUSS MY TREATMENT AT THE TALLAHASSEE PLASTIC SURGERY CLINIC WITH:

1.		Relationship		
2.		Relationship		
Patient's Signature (if minor, parent/legal guardian signature)			Date	

OFFICE USE ONLY

Has patient ever been at TMH? ____ Yes ____ No		Today's Date		Pre-Op Date / Time		Scheduled Date	
Proposed Patient Type ____ Outpatient ____ Inpatient ____ Recurring				Hospital Service			
Diagnosis/ICD-9 Code				Procedure / CPT Code			
Admitting MD				Primary Care Physician			

Surgery Information

Surgery Site		Est OR Time		Height		Weight		Difficult IV Access?	
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Have you ever been to our office before? Yes _____ No _____ If yes, please give reason and date you were previously seen

How did you hear about us? (Please circle one) Doctor, Phone Book, Friend, Newspaper/Magazine, Other _____

REASON FOR VISIT: _____

If Injury, date you were injured _____ Check one _____ Work related _____ Auto _____ Other _____

MEDICATIONS - Please list all of the medication you are currently taking:

ARE YOU ALLERGIC TO ANY MEDICATIONS?

Name of medication _____	Reaction _____
Name of medication _____	Reaction _____
Name of medication _____	Reaction _____

Date of last physical exam _____ Date of last tetanus shot _____

_____ Have you ever been under the care of a psychiatrist/psychologist or had counseling? Yes _____ No _____

Date of last mammogram _____ Location _____ Physician who ordered _____

Are you pregnant or have reason to suspect that you may be pregnant? Yes _____ No _____

Due Date: Month/Year _____ Name of OB doctor? _____

PERSONAL HABITS

Please explain:

Do you drink alcohol?	Yes ___ No ___	How much? _____
Do you smoke?	Yes ___ No ___	How much? _____
Have you ever smoked?	Yes ___ No ___	When did you stop? _____
Do you use drugs, such as marijuana, cocaine, heroin?	Yes ___ No ___	How much? _____
Are you at risk for AIDS or are you HIV positive?	Yes ___ No ___	_____

REVIEW OF BODY SYSTEMS: Do you now or have you ever had any of the following? Please explain.

Problems with eyes, ears, nose, throat, mouth	Yes	___	No	___	_____
					—
Heart or cardiovascular disease	Yes	___	No	___	_____
					—
Shortness of breath, respiratory/lung problems	Yes	___	No	___	_____
					—
Change in bowel habits, intestinal problems	Yes	___	No	___	_____
					—
Kidney/bladder problems, blood in urine	Yes	___	No	___	_____
					—
Muscle problems, broken bones	Yes	___	No	___	_____
					—
Skin problems, rash, cancer, etc.	Yes	___	No	___	_____
					—
Breast problems	Yes	___	No	___	_____
					—
Neurological problems, epilepsy, stroke	Yes	___	No	___	_____
					—
Diabetes, thyroid disorder	Yes	___	No	___	_____
					—
Stroke	Yes	___	No	___	_____
					—
Bleeding tendency	Yes	___	No	___	_____
					—
Other	Yes	___	No	___	_____
					—

FAMILY HISTORY: Does anyone in your immediate family have a history of any of the following? Please explain:

Heart disease	Yes _____	No _____
High blood pressure	Yes _____	No _____
Diabetes	Yes _____	No _____
Stroke	Yes _____	No _____
Cancer (Location)	Yes _____	No _____
Bleeding disorder	Yes _____	No _____
Other	Yes _____	No _____

MEDICAL HISTORY:

Illnesses (Kind)	Date(s)	Were you hospitalized?
_____	_____	Yes _____ No _____
_____	_____	Yes _____ No _____
_____	_____	Yes _____ No _____
Surgeries		
_____	_____	Yes _____ No _____
_____	_____	Yes _____ No _____
_____	_____	Yes _____ No _____

I understand, and have, as correctly as possible, answered the above questions. I give my permission for the taking of photographs and these photographs may be used (if necessary) for submission to my insurance company, and agree to the taking of photographs during the remainder of my treatment as may be necessary for medical or legal purposes. I agree to cooperate fully with all planned and agreed upon care.

Patient Name _____ Patient Signature _____
(If minor, parent/legal guardian signature)

I acknowledge that I have received a copy of the Notice of Privacy Practice for Tallahassee Plastic Surgery Clinic. I understand that I may refuse to sign this acknowledgment.

Patient Name _____ Patient Signature _____
(If minor, parent/legal guardian signature)

If you are a legal representative of the patient, please describe your authority below:

The patient was unable / refused to sign.

Office Staff of Tallahassee Plastic Surgery Clinic.

Date

Please note the following billing policies. We are providers for Capital Health Plan, VISTA, Blue Cross/Blue Shield PPC, Medicare, Tricare and Beechstreet insurances. You will be responsible for any co-payments required by your insurance company at the time of service. We will accept cash, check, debit cards, Visa, MasterCard, American Express, and Discover.

If your insurance company was not listed above, please be aware that you will be responsible for your office visits. We will be happy to file an insurance claim on your behalf provided we have all the correct information.

Office Visits – Full payment is due at the time of service for any insurance carriers that are not listed above.

Co-payment is required at the time of service for any insurance carriers that we are providers for.

Surgery - We do file for non-cosmetic surgery and will wait sixty (60) days for your insurance company to pay. If we do not receive payment by that time, you will be responsible for payment.

We send all tissue specimens for pathological examination and you will be billed directly by the Pathology Department. Anesthesiology and hospital charges will also be billed separately.

IF YOU DO NOT HAVE INSURANCE, PLEASE ASK TO SPEAK TO OUR INSURANCE COORDINATOR ABOUT SPECIAL ARRANGEMENTS. NO PATIENT WILL BE DENIED NON-ELECTIVE MEDICAL OR SURGICAL CARE BECAUSE OF INABILITY TO PAY.

MEDICARE PATIENTS - Please sign the following lifetime authorization.

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information for this or a related **Medicare claim**. I request that payment of authorized benefits be made on my **Medicare claim**. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization furnishing the services to **submit a claim to Medicare** for payment to me.

Patient's Signature (Medicare Only)

Date

ALL OTHER INSURANCE - Please sign the following lifetime authorization.

I authorize payment of medical benefits to the undersigned physician or suppliers for service described and authorize the use of this signature for all insurance submissions.

Patient's Signature (General Insurance)
(if minor, parent/legal guardian signature)

Date