Artisan Plastic Surgery & Renew Skin Care Center

Patient Registration

In order to serve you properly, we need the following information. All information will be kept confidential. **PLEASE PRINT!**

Patient Name:_____ DOB:_____ Age:_____ Sex:_____ **SS#**_____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____ E-Mail_____
Marital Status: S M D W Race: _____ Ethnicity: **Hisp/Latino** or **Non Hisp/Latino** Language: **English** or **Other**
Employer: _____ Occupation_____
Address: _____ City: _____ State: ____ Zip: _____
Emergency Contact:_____ **Relationship:**_____ **Phone:**_____
Primary Care Physician: _____ **Phone:** _____
Pharmacy Name: _____ **Pharmacy Phone #:** _____

Do you have Medical Insurance? YES NO Insurance Name:_____
Policy #: _____ ***Subscriber's*** Name: _____
Group #: _____ ***Subscriber's*** Employer: _____
Subscriber's relationship to patient: _____ ***Subscriber's*** DOB: _____ ***Subscriber's*** SS #_____

Is there Secondary Insurance? YES NO Secondary Insurance Name:_____
Policy #: _____ ***Subscriber's*** Name: _____
Group #: _____ ***Subscriber's*** Employer: _____
Subscriber's relationship to patient: _____ ***Subscriber's*** DOB: _____ ***Subscriber's*** SS #_____

WAS THIS AN ACCIDENT? YES NO Date of injury _____ **WORK/HOME/AUTO** Hospital you visited_____

Who referred you to our office? _____

Patient Medical History

HEIGHT:_____**WEIGHT**:_____

REQUIRED:

LATEX ALLERGY:	**YES**	**NO**
Do you have history of MRSA:	**YES**	**N O**
Do you have SLEEP APNEA?	**YES**	**NO**
Do you have a PACEMAKER?	**YES**	**NO**
Do you have WELL WATER?	**YES**	**NO**

ALLERGIES:

_____
_____
_____
_____

Do you wear dentures? **YES NO**
Do you drink alcohol? **YES NO** If yes, how much? _____
Do you smoke or use tobacco? **YES NO** If yes, how much/often?_____
Have you had a Hysterectomy or Tubal? **YES NO**
Could you be pregnant? **YES NO**
Women Only (if considering surgery):
Bra Size:_____ Did you breastfeed? **YES NO**
#of Pregnancies:_____ Date of Last Mammogram: _____
Do you perform self breast exams? **YES NO**
Have you ever had lumps/discharge? **YES NO**

MEDICATIONS:

_____
_____
_____
_____
_____
_____

Past Surgeries and Dates:_____

FAMILY HISTORY

Breast Cancer Diabetes
Melanoma Stroke
Heart Disease Heart Attack
Anesthesia Complications
Other:_____

PAST MEDICAL HISTORY

Heart Disease	Heart Attack	High Blood Pressure	Mitral Valve Prolapse
Thyroid Disease	Seizures	Stomach Ulcer	Unusual Bleeding
Diabetes	Stroke	Arthritis	Tuberculosis
Asthma	Anemia	Kidney Disease	Mental Illness
Cancer	Hernia	Rheumatic Fever	Hepatitis
Complications with Anesthesia		AIDS or HIV+	Other:_____

I verify that the above information is true and accurate to the best of my knowledge:

Signature of patient:_____ ***Date:***_____
(Patient or Authorized Representative)

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Patient Consents

MEDICARE/MEDICAID:

Statement to permit payment of Medicare Benefit to physician, provider, and patient.

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/ Department of Public Welfare or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid 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 to submit a claim to Medicare/DPW for payment.

ASSIGNMENT OF BENEFITS

I hereby authorize payment of medical benefits per appropriate assignment(s) above to the Physician or organization rendering services, not to exceed the balance due of any aforementioned providers' regular charges for this period of service. I understand that I am financially responsible to the physician for charges not covered by this amount.

_____ _____

Patient or Authorized Representative *Date*

RELEASE OF INFORMATION

I authorize the release of medical records, any related studies, and other information to my family physician, the doctor to whom I am referred, my legal counsel, and to the applicable third-party payer.

_____ _____

Patient or Authorized Representative *Date*

PHOTOGRAPH CONSENT

I authorize and permit Artisan Plastic Surgery to take, obtain and make use of photographs or other images of myself, including appropriate portions of the body, for medical purposes such as insurance authorization and personal comparison. I understand that such photographs or other computer images, copies thereof may be available for use by Artisan Plastic Surgery for patient education without compensation to me. I understand I will be notified and given the option to decline public usage before this action occurs. I further understand that my anonymity will be preserved unless I agree otherwise in writing prior to disclosure of my identity.

_____ _____

Patient or Authorized Representative *Date*

*Are we permitted to use your photos for Advertisement purposes?

_____ _____

Patient or Authorized Representative *Date*

HIPPA RELEASE OF INFORMATION

To insure proper handling & disclosure of your information please complete the following

Home #_____ Cell#_____

Work #_____ E-Mail_____

I authorize the release of pertinent medical information relating to my treatment to:

Please initial your choice(s):

_____May leave message on answering machine at home/work/cell to contact the office.

_____May contact me via e-mail.

_____May release medical information to spouse: Name_____

_____May release medical information to parent(s):

Parent_____

_____May release medical information to designated person.

Name_____

I understand this release will be in effect unless changed or revoked by myself either in writing or by completing a new release. I also understand that certain information is not included in this release, i.e., HIV, mental health, drug/alcohol, and sexually transmitted disease information.

***Signature of patient:*_____*Date:*_____**

(Patient or Authorized Representative)