

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)