Artisan Plastic Surgery & Renew Skin Care Center

Patient Registration – Please Complete ALL Areas

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_____
Employer: _____
Occupation_____
Address: _____
City: _____ State: ____ Zip: _____

Marital Status: **S M D W** Race: _____
Ethnicity Hisp/Latino: **YES NO** Language: English or Other

Emergency Contact:_____
Relationship:_____ Phone:_____

Pharmacy Name: _____
Pharmacy Phone #: _____

Primary Care Physician: _____
Phone #: _____

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

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

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

Who referred you to our office? _____

Patient Medical History

PAST MEDICAL HISTORY

Heart Disease	Heart Attack	High Blood Pressure	Hepatitis
Thyroid Disease	Seizures	Unusual Bleeding	AIDS or HIV+
Diabetes	Stroke	Tuberculosis	Mental Illness
Asthma	Anemia	Kidney Disease	Cancer
Hernia	Complications with Anesthesia		Other:_____

PAST SURGERIES

_____
_____
_____

REQUIRED:
HEIGHT:_____**WEIGHT**:_____

LATEX ALLERGY:	**YES**	**NO**
Do you have history of MRSA:	**YES**	**NO**
Do you have SLEEP APNEA?	**YES**	**NO**
Do you have a PACEMAKER?	**YES**	**NO**
Do you have WELL WATER?	**YES**	**NO**
Do you have a prosthetic heart valve?	**YES**	**NO**

ALLERGIES: **REACTIONS:**

_____ _____
_____ _____
_____ _____
_____ _____

FAMILY HISTORY

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

SOCIAL HISTORY

Do you wear dentures?	**YES**	**NO**
Do you drink alcohol?	**YES**	**NO**
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 breast surgery):
Have you ever had lumps/discharge? **YES NO**
Bra Size:_____ Date of Last Mammogram: _____
#of Pregnancies:_____ #of Children:_____

MEDICATIONS:

_____
_____
_____
_____
_____
_____

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

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

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 hereby grant permission for the use of any of my medical records including illustrations, photographs, or other imaging records created in my case, for use in examination, testing, credentialing, and/or certifying purposes by The American Board of Plastic Surgery, Inc.

_____ _____

Patient or Authorized Representative *Date*

I authorize and permit Artisan Plastic Surgery to make use of photographs or other images of myself, including appropriate portions of the body for private or public advertisement and/or patient education. I understand this use does not entitle me to compensation. 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*

HIPAA 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)

Pain Treatment with Narcotic Medications: Patient Education

You may be prescribed a narcotic medication following procedures at Artisan Plastic Surgery.
Due to the opiod addiction epidemic, there is educational material that you must review prior to being prescribed this medication.

Risks and Common Problems: There are risks linked to narcotic drugs, which include but are not limited to:

 Addiction: There is a risk that you may become addicted to narcotic drugs. This means that you want the drug and will try very hard to get it, even if it causes you harm or problems in your life. This risk is higher if you have struggled with addiction in the past.

 Incomplete pain relief: The narcotic drug you are on may not take away all of your pain. Talk to your doctor if you are still having pain. Your provider may suggest other alternatives to help with your pain.

 Side effects: There are many side effects of narcotic drugs. You may feel itchy, dizzy, or sick to your stomach. You may have changes in your mood or energy level. You may vomit. You may have trouble having a bowel movement. Your provider may discontinue or change your medication to help with these side effects.

 Slowed breathing: If you take a dose that is too high, then you could have slowed breathing. You must only take the dose your doctor prescribes. **Do not use other drugs or drink alcohol while taking narcotic drugs**. This can cause death.

 Slowed reaction time: You may feel sleepy and slow to react. You should not drive, use heavy machines or guns, be at unsafe heights, or be caring for someone else while taking this medication.

 Tolerance: Your body could become used to the dose of narcotic drugs that your provider prescribes, and you may not get the pain relief you had before. A higher dose may not help and could cause side effects. This means other drugs should be used.

More Facts: There are local, state, and federal laws that your provider must follow when prescribing narcotic drugs. Pennsylvania is participating in a drug monitoring program that monitors prescriptions you fill from all providers and all pharmacies. This means that if you have multiple prescribers or multiple narcotic medications, your providers, pharmacy or insurance may restrict narcotic refills.

Surgical patients will receive a maximum of <u>30</u> count supply of narcotic medication. This should last for the first week. After that point, we will discuss your need for pain control and provide you with alternative options to narcotics.

Pain Treatment with Narcotic Medications: Patient Agreement

I, _____understand and voluntarily agree that
(initial each statement after reviewing)

____I have been provided and understand the Patient Education information regarding narcotic medication.

____I will keep the medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until office hours, and may not be replaced at all.

____I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the treatment team.

____I will not call at night or on the weekends looking for refills. I understand that prescriptions will be filled only during office hours, and that due to state regulations, I may be required to pick the prescription up in person.

____I will treat the staff at the office respectfully at all times. I understand that they are responsible to adhere to all local, state, and federal laws.

____I will not sell this medicine or share it with others.

____I will tell the doctor about all other medicines that I take, and let him/her know right away if I have a prescription for a new medication.

____I will use only one pharmacy to get all on my medicines:

Pharmacy name_____
Location_____
Phone#_____

_____ _____
Patient Signature Date