

Artisan Plastic Surgery

Patient Registration – All information will be kept confidential

Patient Name: _____ DOB: _____ Age: _____ Sex: _____ SS #: _____ - _____ - _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____
 E-Mail: _____ Occupation: _____
 Who referred you: _____ Primary Care Physician: _____

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

Emergency Contact: _____
 Relationship: _____ Phone: _____
 Pharmacy Name: _____
 Pharmacy Phone #: _____

What is your Gender Identity? **What sex were you assigned at birth?**

Female Female
 Transgender Female Male
 Male
 Transgender Male

ACCIDENT Date of injury _____ WORK / HOME / AUTO

Primary Insurance

Insurance Name: _____
 Policy #: _____
 Group #: _____
 Subscriber's Name: _____
 Subscriber's Employer: _____

Secondary Insurance

Insurance Name: _____
 Policy #: _____
 Group #: _____
 Subscriber's Name: _____
 Subscriber's Employer: _____

MEDICAL HISTORY

REQUIRED: **HEIGHT:** _____ **WEIGHT:** _____ BMI: _____ **PLANNED PROCEDURE:** _____

<p>CARDIOVASCULAR:</p> <input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> HEART ATTACK <input type="checkbox"/> BYPASS SURGERY <input type="checkbox"/> HEART STENTS <input type="checkbox"/> HEART VALVE PROBLEM <input type="checkbox"/> PACEMAKER / ICD <input type="checkbox"/> AFIB / AFLUTTER <input type="checkbox"/> SVT / VTACH <input type="checkbox"/> OTHER: _____	<p>NEUROLOGICAL:</p> <input type="checkbox"/> STROKE <input type="checkbox"/> TIA <input type="checkbox"/> GLAUCOMA <input type="checkbox"/> SEIZURES <input type="checkbox"/> MS <input type="checkbox"/> MUSCULAR DYSTROPHY <input type="checkbox"/> SPINAL CORD INJURY <input type="checkbox"/> DEMENTIA/ MEMORY LOSS / CONFUSION <input type="checkbox"/> NEUROPATHY <input type="checkbox"/> OTHER: _____	<p>PULMONARY:</p> <input type="checkbox"/> SMOKER QUIT DATE: _____ <input type="checkbox"/> VAPE <input type="checkbox"/> ASTHMA <input type="checkbox"/> OXYGEN USE <input type="checkbox"/> COPD/EMPHYSEMA <input type="checkbox"/> SLEEP APNEA <input type="checkbox"/> USE CPAP/BIPAP	<p>HEMATOLOGY/ONCOLOGY:</p> <input type="checkbox"/> CANCER: _____ <input type="checkbox"/> CHEMOTHERAPY <input type="checkbox"/> RADIATION <input type="checkbox"/> ABDOMINAL ANEURYSM <input type="checkbox"/> FACTOR V <input type="checkbox"/> HEMOPHILIA <input type="checkbox"/> VON WILLEBRAND'S <input type="checkbox"/> BLOOD CLOT: _____ <input type="checkbox"/> RECENT (PAST YR) ANEMIA <input type="checkbox"/> ON BLOOD THINNER (OTHER THAN ASPIRIN): _____	
<p>RENAL:</p> <input type="checkbox"/> RENAL INSUFFICIENCY <input type="checkbox"/> DIALYSIS <input type="checkbox"/> INABILITY TO URINATE AFTER SURGERY	<p>MENTAL HEALTH:</p> <input type="checkbox"/> ANXIETY <input type="checkbox"/> DEPRESSION <input type="checkbox"/> BIPOLAR <input type="checkbox"/> OTHER: _____	<p>ENDOCRINE:</p> <input type="checkbox"/> DIABETES <input type="checkbox"/> INSULIN PUMP <input type="checkbox"/> HYPOTHYROID <input type="checkbox"/> HYPERTHYROID <input type="checkbox"/> WEIGHT LOSS PRESCRIPTION (please list): _____	<p>GYNECOLOGIST HX:</p> <input type="checkbox"/> MENOPAUSE >1YR <input type="checkbox"/> HYSTERECTOMY <input type="checkbox"/> POSSIBLE PREGNANCY	
<p>GASTROINTESTINAL:</p> <input type="checkbox"/> HEPATITIS <input type="checkbox"/> ULCERS/HEARTBURN/REFLUX	<p>SOCIAL:</p> <input type="checkbox"/> ALCOHOL USE <input type="checkbox"/> MARIJUANA USE <input type="checkbox"/> IN RECOVERY FOR: <input type="radio"/> DRUGS <input type="radio"/> ALCOHOL PRESCRIPTION FOR RECOVERY _____	<p>OTHER:</p> <input type="checkbox"/> WELL WATER <input type="checkbox"/> HISTORY OF MRSA <input type="checkbox"/> HISTORY OF VRE	<p>FUNCTIONAL STATUS:</p> <p style="text-align: center;">DO YOU HAVE SHORTNESS OF BREATH?</p> <input type="checkbox"/> AT REST <input type="checkbox"/> WALKING UP STAIRS <input type="checkbox"/> AT NIGHT	
<p>PAST SURGERIES:</p> _____ _____ _____		<p>MEDICATIONS:</p> _____ _____ _____		<p>ALLERGIES:</p> <input type="checkbox"/> LATEX
<input type="checkbox"/> LABS ORDERED		<input type="checkbox"/> CLEARANCE ORDERED		

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

Patient Signature: _____
 Staff Signature: _____

Date: _____
 Date: _____

Time: _____
 Time: _____

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)

Artisan Plastic Surgery

Pain Treatment with Narcotic Medications: Patient Education

You may be prescribed a narcotic medication following procedures at Artisan Plastic Surgery.

Due to the opioid 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 30 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.

Artisan Plastic Surgery

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