# DENTON PLASTIC SURGERY

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## PATIENT INFORMATION / AUTHORIZATION FORM

**(Please Print Clearly)**

**Patient Name**:_____ **Sex**: ☐ F ☐ M
(Last) (First) (MI)

**Address:**_____

**City**:_____ **State**:_____ **Zip**:_____

**SS#**:_____ **Date of Birth**:_____ **Age**:____ **Marital Status**: ☐ S ☐ M ☐ D ☐ W

**DL# or ID#:**_____

**Home Phone**:_____ **Work Phone**:_____ **Cell Phone**:_____

**Email Address:**_____

**Race**: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hispanic/Latino
☐ Native Hawaiian or Pacific Island ☐ White ☐ More than one race ☐ Decline to Answer

**Ethnicity**: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline to Answer

**Patient Speaks English?** ☐ Yes ☐ No

**Preferred Language**: ☐ English ☐ Spanish ☐ Other _____

**Preferred Communication Method**: ☐ US Mail ☐ Home Phone ☐ Cell Phone ☐ Work Phone

## EMERGENCY CONTACT

**Last Name:**_____ **First Name:**_____

**Relationship:**_____ **Home Phone:**_____

**Work Phone:**_____ **Cell Phone:**_____

## MEDICAL CARE INFORMATION

**Primary Care Physician:**_____ **Phone Number:**_____

**Preferred Pharmacy:**_____ **Phone Number:**_____

**Pharmacy Address:**_____

**Referred by:**_____

**Do you have medical Insurance?:** ☐ Yes ☐ No

**Reason for visit?**_____

**Have you had plastic surgery before?:** ☐ Yes ☐ No If yes, please describe_____

_____

## HEALTH HISTORY

**Height**_____ **Weight**_____

**List Allergies**_____

**Reaction**_____

**List all medications you are currently taking**_____

_____

_____

**List previous surgeries and dates**_____

_____

| YES | NO | |
|---|---|---|
| ☐ | ☐ | **Do you have a history of heart disease, chest pain or high blood pressure?** |
| ☐ | ☐ | **Do you have trouble breathing, asthma, bronchitis or chronic cough?** |
| ☐ | ☐ | **Do you have a history of sleep apnea?** |
| ☐ | ☐ | **Do you or have had ever had cancer?** |
| ☐ | ☐ | **Do you or have you ever had hepatitis or liver disease?** |
| ☐ | ☐ | **Do you have diabetes or high blood sugar?** |
| ☐ | ☐ | **Do you or have you ever had kidney or bladder disease?** |
| ☐ | ☐ | **Do you or have you ever had stomach trouble or ulcers?** |
| ☐ | ☐ | **Do you or have you ever had neck / back / arm / leg pain, numbness or weakness?** |
| ☐ | ☐ | **Do you take large amounts of aspirin, ibuprofen or vitamin E? If so, why?**_____ |
| ☐ | ☐ | **Do you have a history of bleeding problems or blood clots?** |
| ☐ | ☐ | **Do you ever get fever blisters or "cold sores"?** |
| ☐ | ☐ | **Do you or did you smoke? If so, how much?**_____ |
| ☐ | ☐ | **Have you ever had a reaction to local or general anesthetic?** |
| ☐ | ☐ | **Have you ever been under the care of a psychiatrist or psychologist?** |
| ☐ | ☐ | **Do you accept the fact that medicine is not an exact science?** |
| ☐ | ☐ | **Do you accept the fact that every medical / surgical treatment is associated with risks?** |
| ☐ | ☐ | **Do you have MRSA, chronic infection or abscess?** |
| ☐ | ☐ | **Do you have a history of poor scaring or keloids?** |
| ☐ | ☐ | **Females: Could you be pregnant? Last Menstrual** _____ |
| ☐ | ☐ | **Females: Do you have a history of breast disease or irregular mammograms?** |
| ☐ | ☐ | **Do you have a family history of blood clots, bleeding or anesthesia complications?** |

**Any other family history:** _____

_____

**Employer/School:**_____ **Occupation:**_____

**Employer/School Address:**_____

**Employer/School Phone Number:**_____ **Employment Status:** ☐ Full Time ☐ Part Time

**Father's Name:**_____ **Contact Phone Number:**_____

**Mother's Name:**_____ **Contact Phone Number:**_____

## ASSIGNMENT OF BENEFITS AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to Denton Plastic Surgery / MP Plastic Surgery, PLLC all medical benefits, if any, otherwise payable to me for services rendered. I assign my right to receive these payments to Denton Plastic Surgery / MP Plastic Surgery, PLLC. I authorize Denton Plastic Surgery / MP Plastic Surgery, PLLC to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my Health Insurance Plan will not direct payment to Denton Plastic Surgery / MP Plastic Surgery, PLLC, I agree to forward any and all health insurance payments, which I receive for the services rendered directly to Denton Plastic Surgery / MP Plastic Surgery, PLLC. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ (*initials)*

## MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Denton Plastic Surgery / MP Plastic Surgery, PLLC for any services furnished to me by that group. I authorize the release of medical information needed to determine these benefits. My signature below authorizes payment to be made directly to Denton Plastic Surgery / MP Plastic Surgery, PLLC and, if other health insurance is in effect as a supplemental policy, I further authorize payment to Denton Plastic Surgery / MP Plastic Surgery, PLLC and also authorize the release of information to that company for payment of benefits._____*(initials)*

## TREATMENT AUTHORIZATION

I authorize physicians, nurse practitioners and/or their assistants to provide the medical care, tests, procedures, services and supplies considered advisable by my provider. These services will be further explained to me in detail and I will be given additional opportunity to consent individually to procedures ordered by my physician prior to my receiving treatment. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consent timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, B and C and HIV._____*(initials)*

**Signature of Patient/Person Legally Responsible:**_____

**Relationship to Patient:**_____

**Date**:_____

Your signature below acknowledges that you were made available the **Notice of Privacy Practices** that provide a description of information uses and disclosure practices. You accept and understand that you:

- Have the right to review the **NOTICE** prior to signing this consent.
- Accept that the practice reserves the right to change the **NOTICE** and its information practices.
- Have the right to request restrictions on the use or disclosure of your health information to carry out treatment, payment or healthcare operations and to correct error(s) in your record. The practice, however, is not required to agree to the restrictions requested and some services may be unavailable to you depending upon the requested restrictions.
- May revoke this consent in writing that YOU provide to the practice. The revocation does not apply to any uses of your information made by the practice in reliance upon this consent form and on the belief that your consent was still effective. Initials of patient or person authorized to sign HIPAA Notice for patient_____(*initials*)
- I authorize for detailed messages to be left on an at home answering machine or voicemail service._____(*initials*)
- I authorize for detailed message to be left on a cell phone voicemail._____(*initials)*
- I agree and offer no objection to the verbal release of protected health information to the person(s) listed below. I also authorize them to pick up prescriptions, notes and other medical information on my behalf._____(*initials*)

| Name | Relationship | Phone Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## PATIENT CONSENT FOR CONSULTATION

I give my permission for examination and photographs during consultation for the purpose of making an evaluation with regard to my care and treatment._____(*initials*)

## PATIENT CONSENT FOR USE OF HEALTH INFORMATION

I give my 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. I understand that the Board requires that all identifiable characteristics, with the exception of a full face photograph or photograph of a uniquely identifiable characteristic, be blacked out for submission of materials for the Oral Examination of The American Board of Plastic Surgery to protect patient privacy._____(*initials)*

**I have read all parts of the patient information and authorization form supplied to me by Denton Plastic Surgery / MP Plastic Surgery, PLLC.**

_____ _____

Patient / Guardian Signature Date

_____ _____

Print Name of Patient Date of Birth

_____

Relationship to Patient