DRS. CHASE and McCORD

PATIENT INFORMATION

DATE:_____

NAME:_____
FIRST MIDDLE LAST NAME USED

ADDRESS:_____RD., ST., DR., AVE., PK., CR.

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ WORK PH:_____ CELL PH:_____

SOCIAL SEC. #:_____ DATE OF BIRTH:_____ AGE:_____ SEX: MALE / FEMALE

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED E-MAIL ADDRESS:_____

OCCUPATION:_____ EMPLOYER:_____ ADDRESS:_____

SPOUSE OR PARENT INFORMATION

SPOUSE/PARENT'S NAME:_____ SOCIAL SEC. #:_____

SPOUSE/PARENT'S EMPLOYER:_____ ADDRESS:_____

SPOUSE/PARENT'S PHONE:_____

NEAREST RELATIVE OUTSIDE

HOUSEHOLD:_____

RELATIONSHIP TO THE

ABOVE:_____PHONE:_____

INSURANCE INFORMATION

PRIMARY:_____ SECONDARY:_____

GROUP/EMPLOYER:_____ GROUP/EMPLOYER:_____

INSURED:_____ INSURED:_____

DATE OF BIRTH OF INSURED:_____ DATE OF BIRTH OF

INSURED:_____

I.D. #:_____ I.D. #:_____

GROUP #:_____ GROUP #:_____

DEDUCTIBLE: $_____.00 DEDUCTIBLE: $_____.00

IF ACCIDENT, DATE OF INJURY:_____ WORKER'S COMP._____ AUTO ACC._____

Date _____

Dr. Chase ☐ Dr. McCord ☐

Patient Name _____ Date of Birth _____

Age _____ Weight _____ Height _____ Reason for Visit _____

Primary Care Dr _____ Referring Dr or Person _____

Prescription Medication _____

_____

Vitamins/Herbs/Over-the-Counter Medication _____

Please check if appropriate. Do you take: Aspirin ☐ Fish Oil ☐ Diet Pills/Phentermine ☐ Pain Meds ☐

Allergies _____

Previous Hospitalizations _____

Previous Surgeries _____

Past Medical History	**Yes**	**No**
Heart Disease		
High Blood Pressure		
Bleeding Tendency/Blood Clots		
Asthma/Bronchitis/Tuberculosis		
Cancer. If so, where?		
Diabetes (circle): Type 1 Type 2		
Depression/Mental Disorder		
Hepatitis/AIDS/HIV+		
Thyroid Disease		
Arthritis		
Gastric Bypass/Gastric Sleeve/Gastric Band		
Sleep Apnea/Sleep with C-PAP		
Other		
Illness		
Family History:	**Yes**	**No**
Has any blood relative had the following?		
Cancer. If so, type		
Heart Disease/High Blood Pressure		
Diabetes		
Social History Do you have a history of…	**Yes**	**No**
Smoking. If so, how much?		
Alcohol Use		
Illicit Drug Use		

Women Only
Number of Pregnancies
Number of Children
Did you Breast Feed?
Date of Last Mammogram
Have you had any surgery to your breast?
If Applicable:
Current bra size
Ideal bra size

Review of Systems:		
Do you have the following? Please circle.	**Yes**	**No**
Excessive Scarring/Keloids		
Dry Eyes		
Chronic Cough/Shortness of Breath		
Chest Pain		
Rapid or Irregular Heartbeat		
Skin Rash		
Intestinal Problems		
Joint or Muscle Pain		
Swollen Lymph Nodes		
East Bleeding/Bruising		
Blood Disorder		
Weight Gain/Weight Loss		
Acid Reflux/GERD/Heartburn		

AUTHORIZATIONS AND RELEASES

We want to welcome you to our practice. We want to make your experience with every aspect of our service meet or exceed your expectations. If you have any questions or concerns, suggestions for improvement in our services, or any comments, please do not hesitate to speak with any of our staff or physicians. Listed below are several notices that outline certain responsibilities of yours, and ours. Please read them carefully and sign where indicated that you have read each statement.

Are you interested in financing your surgery? Yes Maybe No

I give my permission to use my pictures for education purposes: Yes No

FINANCIAL POLICY/ASSIGNMENT OF BENEFITS

The initial consultation fee is due on the day you are seen. If applicable, insurance will be filed for your visit. Cosmetic surgery is due two weeks prior to surgery. On all other surgeries, your co-payment and/or deductible will be due prior to surgery or specifically arranged with our business office.

As a courtesy to our patients, the practice will accept assignment for many commercial insurance programs and Medicare. We will file your primary insurance claim for you. Once the primary insurance has paid, we will also file your secondary insurance, if you have provided us with that information. However, insurance is a contract between you and your insurance company. Therefore, we ask that you acknowledge your responsibility for the payment for our services. If the insurance denies coverage, disallows a service, or otherwise does not pay the claim, you are still responsible for the fees. In addition, if the fees for our services are not paid, we may turn the account over to a collection agency. If an account is turned over for collection, their fees, attorney's fees and court cost will be added to the account balance. Also, your insurance company may ask us to provide information concerning your treatment before they will pay the services.

I acknowledge responsibility for payment of fees for services provided by the practice and authorize the practice to release any medical information, if necessary, to my insurance company.

_____Patient/Guarantor_____Date

PRIVACY POLICY

New federal regulations require physician practices to keep your medical information private. Our practice has always guarded the privacy of our patients. We only share your medical information with other healthcare providers that are participating in your care, your insurance company to provide benefits, or for medical management issues. If anyone else helps us with our internal operations, we will require them to keep any patient information they may see confidential. All other releases of information have to be specifically authorized by you. If you ask us to account for these releases of information, we will provide that to you. You may also request and receive a copy of your medical record and ask questions about its content. We will keep your record as long as you are a patient of the practice and seven years after your last visit.

I acknowledge that I have been informed about the privacy of my medical record and have been given a copy of the *NOTICE OF PRIVACY PRACTICES* from Associates in Plastic & Reconstructive Surgery, P.C.

_____Patient_____Date

CONSENT TO TAKE PHOTOGRAPHS

I hereby authorize my physician and /or his staff to take pre-operative, intra-operative, and post-operative photographs. I understand these pictures will be a part of my record

_____Patient or Parent if patient is a minor

Associates in Plastic and Reconstructive Surgery
Consent to Discuss Medical Care

Printed Name _____

Date of Birth: _____

I authorize APRS to discuss my medical information with the following individual listed below. (Please print name below)

Name _____ Relationship_____

I give my permission for APRS to leave medical information including lab results at my phone number listed on forms. _____Yes _____ No

I give my permission for APRS to discuss any medical information from this office with a 3rd party such as Insurance Companies or other treating Physicians. Yes _____ No ___

Signature of Patient, Parent or Legal Guardian_____

Printed name of signature above _____

Date signed _____