

## Patient History & Physical

Today's Date: \_\_\_\_\_

Patient Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Age: \_\_\_\_\_

What is the reason for today's visit? \_\_\_\_\_

Date symptoms first started \_\_\_\_\_ Was this job-related? Yes \_\_\_ No \_\_\_

Primary Care Physician: \_\_\_\_\_ Who may we thank for referring you? \_\_\_\_\_

Have x-rays been made? \_\_\_\_\_ Where and When? \_\_\_\_\_

Please list any medical problems you have:

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Past Hospitalizations and/or Surgeries \_\_\_\_\_

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Family History: (Check all that apply)

<input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes	<input type="checkbox"/> Problem with Anesthesia <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Other _____	<input type="checkbox"/> Cancer (Type _____)
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Drug allergies: (Please check one) Yes \_\_\_ No \_\_\_ If Yes, please list: \_\_\_\_\_

Current Medications	Dose	Current Medications	Dose

Pharmacy Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Patient History & Physical** continued

Do you smoke? (check one) Yes\_\_\_ No\_\_\_ If Yes, how much? \_\_\_\_\_ How many years? \_\_\_\_\_

Do you drink alcohol? (check one) Yes\_\_\_ No\_\_\_ If Yes, how much? \_\_\_\_\_

**Please check any box below to indicate whether you have had, or are currently having, any of these problems:**

<input type="checkbox"/> Headaches	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Reaction to Anesthesia	<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Double vision	<input type="checkbox"/> Blood in stools	<input type="checkbox"/> Does anyone in your family?	<input type="checkbox"/> Pain on swallowing
<input type="checkbox"/> Blocked nose	<input type="checkbox"/> Pain on urination	<input type="checkbox"/> Chills	<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Earache	<input type="checkbox"/> Coughing up blood
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Recent Trauma	<input type="checkbox"/> Bleed or bruise easily
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> High blood pressure		<input type="checkbox"/> Do you have depression?
<input type="checkbox"/> Stomach pain	<input type="checkbox"/> Diabetes		
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Arthritis		
<input type="checkbox"/> Nausea	<input type="checkbox"/> Seizures		

Have **you** taken any aspirin in the last two weeks? No\_\_\_ yes\_\_\_, when? \_\_\_\_\_

Have we ever seen any other member of your family? No Yes If yes who? \_\_\_\_\_

### Patient Information

**Patient Name:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age:** \_\_\_\_ **Sex:** \_\_\_\_ **Marital Status:** Single\_\_ Married\_\_ Divorced\_\_ Widowed\_\_

**Race:** \_\_\_\_\_ **Primary Language:** \_\_\_\_\_ **Ethnicity:** Hispanic\_\_ Non-Hispanic\_\_ Unknown\_\_

**Mailing Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Work Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone#:** \_\_\_\_\_ **Cell Phone#:** \_\_\_\_\_ **Work Phone #:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_ **Do you want email updates?** Yes \_\_ No \_\_

### Responsible Party (If different from patient) ~ Parent or guardian if patient is a minor

**Name:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Mailing Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Work Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone #:** \_\_\_\_\_ **Cell #:** \_\_\_\_\_ **Work Phone#:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Spouse or other Parent Name:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Mailing Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Work Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone #:** \_\_\_\_\_ **Cell #:** \_\_\_\_\_ **Work Phone#:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

### Insurance Information: (Please allow receptionist to copy cards)

**Primary Insurance:** \_\_\_\_\_ **Policy #:** \_\_\_\_\_

**Name of Policy Holder:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **S.S. #:** \_\_\_\_\_ **Relationship to Patient:** Self\_\_ Spouse\_\_ Child\_\_ Other: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ **Policy #:** \_\_\_\_\_

**Name of Policy Holder:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **S.S. #:** \_\_\_\_\_ **Relationship to Patient:** Self\_\_ Spouse\_\_ Child\_\_ Other: \_\_\_\_\_

**Emergency Contact Name:** \_\_\_\_\_ **Phone #(s):** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Emergency Contact Name:** \_\_\_\_\_ **Phone #(s):** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

## Financial Policies

### Financial Agreement

I hereby agree to pay for all office visits at the time services are rendered unless I make arrangements in advance. If hospitalization is necessary, I understand that payment is due upon receipt of statement indicating the balance is due and payable by me. I also understand that insurance does not relieve me of the responsibility to pay.

**Authorization to Release Information** I hereby authorize Savannah Facial Plastic Surgery to furnish my insurance company(s), hospital, referring physicians, and attorneys all information with regard to my medical care. This may include information related to HIV, substance abuse, sexually transmitted diseases, or psychiatric treatment.

**Authorization for Assignment of Benefits** I hereby authorize payment directly to Savannah Facial Plastic Surgery surgical and/or medical benefits, if any, otherwise payable to me under the terms of my insurance.

**Authorization for Medicare Benefits** I request that payment of authorized Medicare benefits be made either to me or on my behalf to Savannah Facial Plastic Surgery for any services furnished by the physician/supplier. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents to determine these benefits payable to related services. I understand my signature request that payment be made authorized and release of medical information necessary to pay the claim. If items 9 or HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge; I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductibles are based upon charge determination of the Medicare carrier.

**Champus Release** I request that payment of authorized benefits be made either to me or on behalf to Savannah Facial Plastic Surgery for any services furnished by that physician. I authorize any holder of medical information about me to be released to Champus and its agents to determine the benefits payable for related services.

**Cancellation and No Show Policy** Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. It is therefore requested that if you must cancel your appointment you provide 24 hours notice. Office appointments which are cancelled with less than 24 hours notification may be subject to a \$25 cancellation fee. Patients who do not show up for their appointment without a call to cancel will be considered a NO SHOW. Patients are subject to a \$25 fee for office appointment No Show and \$100 Surgical Procedure No Show fee. This fee is the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

Managed Care mandates that you use in-network physicians, hospitals, labs and services in order to receive in-network payment. Failure to notify your provider of in-network requirements will result in nonpayment or penalty of payment by your insurance company and will result in your being billed for services rendered. If referral numbers and/ or authorization for services requests are required by your plan, please notify this office prior to and services being rendered so that you will not be penalized. It is your responsibility to obtain referral numbers and/ or authorization from your primary care provider.

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**Please check your INSURANCE Company's preferred place of service.**

Hospital:

- ☐ Memorial Health University Medical Center
- ☐ St. Joseph's/ Candler Health System

Lab work:

- ☐ Quest
- ☐ Memorial Hospital Laboratory
- ☐ Lab Corp (BCBS, HMO, POS)
- ☐ St. Joseph's/Candler

If you are unable to provide us with this information before you leave, we will send your labs to the most cost-effective laboratory. This may NOT be the lab your insurance company prefers or will pay for.

I have read the above information and I understand that I am responsible for bills that may arise due to inaccurate information given at this time.

**Patient Signature:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

## PATIENT RECORD OF DISCLOSURES

In general, HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications of PHI by alternative means, such as sending correspondence to the individual's office instead of their home. **I wish to be contacted in the following manner:(check all that apply):**

- ☐ Work Telephone, o.k. to leave message with detailed information
- ☐ Work Telephone, leave message with call-back number only
- ☐ Home Telephone, o.k. to leave message with detailed information
- ☐ Home Telephone, leave message with call-back number only

Written Communication Email Address: \_\_\_\_\_

- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office
- ☐ O.K. to fax to this telephone number: \_\_\_\_\_

You may leave messages with, discuss my treatment, appointments or other scheduling that may occur or give other information as necessary with the following family, friends or personal representatives. You may release a copy of my medical records to the person(s) listed below. I understand that Savannah Facial Plastic Surgery will refuse to discuss my information with anyone not listed below, except in an emergency. I also understand that this consent does not apply to medical providers.

PLEASE PRINT

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Patient's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please print name:** \_\_\_\_\_

**Acknowledgment of Receipt of Privacy Notice:** I have been presented with a copy of Savannah Facial Plastic Surgery Notice of Privacy Practices, detailing how information may be used and disclosed as permitted under federal and state law.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_ If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: \_\_\_\_\_ Witnessed by: \_\_\_\_\_

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**(FOR Savannah Facial Plastic Surgery)**

If patient or patient's representative refuses to sign acknowledgment of receipt of notice, please document the date and time the notice was presented to patient and sign here:

**Presented by:** \_\_\_\_\_ **(name & title)**