

# ***Patient Information***

Patient Name:

*Last First Middle*

Date of Birth: / / Social Security Number: - -

Mailing Address:

*Street City State Zip*

Cell Phone: Home Phone:

Email: Would you like to receive our monthly email newsletter? *Yes No*

What is your preferred means of contact?

Marital Status: *Single Married Divorced Widowed Other*

Race: *Black OR African American American Indian OR Alaska Native Asian Hawaiian OR Other Pacific Islander White Other Race*

Ethnicity: *Hispanic OR Latino Not Hispanic OR Latino Unknown*

Preferred language:

Employer: Job title:

Are you a student? If yes: *Full Time Part Time*

***Emergency Contact Information***

Name: Relationship to patient:

*Last First Middle*

Cell Phone: Home Phone:

***Insurance Information***

Primary Insurance Company: Secondary Insurance Company:

Policy Holder Name:

*Last First Middle*

Date of Birth: / / Social Security Number: - -

Employer: Job title:

Contact Phone Number:

Preferred Pharmacy:

*(please include cross roads and city)*



### ***Patient Name:***

*Last First Middle*

### ***Referring Doctor:***

***Primary Care Physician: Specialists:***

***Reason for visit today:***

***Medications*** *N/A* ***Allergies*** *N/A (including over the counter & herbal supplements)*

***List any previous hospitalizations*, surgeries, injuries *year***

### ***Social History***

Use of alcohol Never Rarely Socially Daily

Use of tobacco Never Rarely Socially Daily Pack(s) per day: Use of recreational drugs Never Type/Frequency:

### ***Family Medical History***

|  |  |  |  |
| --- | --- | --- | --- |
|  | Age | Diseases | If deceased, cause of death |
| Father |  |  |  |
| Mother |  |  |  |
| Sibling(s) |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Child(ren) |  |  |  |
|  |  |  |  |

***Personal Health History*** (Circle all that apply)

|  |  |  |
| --- | --- | --- |
| Diabetes | Arthritis/gout | Hereditary defects |
| High Blood Pressure | Convulsions | Difficulty breathing/asthma/COPD |
| Cancer | Bleeding tendency |  |
| Stroke | Acute infections | Mammogram Date: / / |
| Heart Trouble | Venereal disease | Colonoscopy Date: / / |

#### RELEASE OF INFORMATION

I authorize Wichita Surgical Specialists, P.A. to release any information to any physician involved in my care, hospital, and/or my insurance company including the diagnosis and the records of any treatment for examination rendered to me during the period of such medical and surgical care.

#### ASSIGNMENT OF BENEFITS

I authorize and request payments of insurance benefits directly to Wichita Surgical Specialists, P.A. otherwise payable to me. I further certify I have provided Wichita Surgical Specialists, P.A. a complete list of the insurance companies with which I have medical and/or surgical coverage.

#### FINANCIAL AGREEMENT

I understand that my insurance company or payer of my health benefits may pay less than actual charges for services. I understand I am financially responsible for payments in full of all co-payments, deductibles and/or remaining balances as specified by my insurance plan. If payment is denied or not covered by my insurance, or I have no insurance, I agree to be responsible for payment in full.

SIGNATURE DATE

---(P-AT IE\_N\_T\_OR GU\_A\_RD\_IA\_N\_ \_IF-PAT IE NTIS A MIN\_O\_R\_) ---------

PATIENT NAME (please print) \_

ADDRESS---------------------- ---------------

CITY & STATE-----------------------------------

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received a copy of the Wichita Surgical Specialists, P.A. Notice of Privacy Practices. PATIENT NAME (please print) \_

SIGNATURE ---------- --- -------\_ DATE \_

(PATIENT OR GUARDIAN IF PATIENT IS A MINOR)

**ATTENTION MEDICARE PATIENTS ONLY**

••TO BE COMPLETED FOR ALL MEDICARE PATIENTS••

NAME-------------- ------- DATE OF SERVICE---------

As a direct result of mandated Medicare Secondary Payer (MSP) regulations, we are required to gather the following information to determine if Medicare is your primary insurance.

1. Is the illness/injury due to an automobile accident, liability accident, Workman's Compensation or other? DYes DNo
2. Is illness covered by the Black Lung Program or Veterans Administration program? DYes DNo
3. If under 65, are you a renal dialysis patient in your first 30 months of Medicare entitlement? DYes DNo 4a. If under age 65, is your Medicare coverage due to disability? DYes DNo 4b. Is patient covered by a large group health plan through patient's employer or spouse's

current employer?

1. If 65 and over, is patient covered by Employer Group Health Plan through patient's or spouse's current employer?
2. Are the services to be paid by a Government Research Program?
3. Has the Department of Veteran Affairs authorized and agreed to pay for your care at this facility?

#### REGISTRAR NOTES:

* 1. If patient responds "no" to questions 1-7, Medicare is primary.

DYes DNo

DYes DNo DYes DNo DYes DNo

* 1. If patient responds "yes" to any questions, Medicare is secondary and primary insurance information must be obtained.

#### ONE TIME AUTHORIZATION

I request that payment of authorized Medicare Benefits be made to me or on my behalf to the Physicians of Wichita Surgical Specialists, P.A. for any services furnished to me by that group. I authorize any holder of medical information about me to release to the Centers of Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits payable for related services.

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SIGNATURE DATE \_

(PATIENT OR GUARDIAN IF PATIENT IS A MINOR)



# ***Photography/Video Consent and Release***

I consent to the taking of photographs and/or video by staff of Plastic Surgical Specialists of me and/or parts of my body in connection with plastic surgery procedure(s) performed by Plastic Surgical Specialists.

I understand that photographs and/or video will be taken by staff of Plastic Surgical Specialists of me or parts of my body before, during, and after my procedure(s) as a routine part of my medical care.

I further consent to the use of photographs and/or video for professional medical purposes including but not limited to medical publication, lay publication, medical education, patient education or during presentations to medical or lay groups. I understand that neither I, nor any member of my family will be indentifed by name in any publication. I understand that in some circumstances that photographs may portray features that will make my identity recognizable.

I consent to further use of photographs and/or videos: (Please initial Yes or No)

Yes No In photo albums for the education of Plastic Surgical Specialists patients

Yes No On the Plastic Surgical Specialists website

Yes No Publication in other advertising media representing and/or marketing such as brochures, print adver- tisments, television and/or other media outlets

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.

I understand and agree that I will not receive any compensation for use of photographs and/or video and I waive any right for myself, my spousal community or my heirs to receive any compensation. I agree to hold harmless Plastic Surgical Special- ists and its associated physicians and any and all employees from all cliams and liabilites whatsoever in law and in equity arising from disclosure and use of media as authrized in this consent.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information, including photographs and video, will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Plastic Surgical Specialists.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further under- stand that I have the right to revoke this authorization in writing at any time, but if I do so, it will not apply to or cause the retraction of previously published, disclosed, or used media.

By signing below, I acknowledge and certify that I have read, understood and agree to the terms of this consent.

/ /

Patient’s Name Patient’s Signature Date

Witness



   



Patient Name: Date of Birth: / /

# ***SYSTEMIC***

Fatigue/Weakness Recent change in weight Fever

Chills

Recurrent infections Night sweats

(only circle the symptoms that apply today)

# ***GENITOURINARY***

Burning with urination Difficulty starting stream Urinating at night Urinary incontinence Slow urinary stream Urinary frequency

***PSYCHIATRIC***

Depression Anxiety

Feeling nervous

***BREAST***

Breast lump

***EYES/EARS/NOSE/THROAT***

Eye pain Blurred vision Sore throat Sinus pain

Hearing problems Nosebleeds

***NEUROLOGICAL***

Dizziness Numbness Tremors Tingling Convulsions Headache

Memory lapses or loss

***RESPIRATORY***

Cough Wheezing

Shortness of breath Blood in sputum

***CARDIOVASCULAR***

Palpitations

Leg pain with exertion Chest pain

Ankle swelling High blood pressure

Blood in the urine

***GASTROINTESTINAL***

Abdominal pain Constipation Diarrhea Nausea Vomiting

Decrease in appetite Difficulty swallowing Heartburn

Belching Bloating

Change in the stools Rectal pain

***MUSCULOSKELETAL***

Neck pain Diffuse joint pain Back pain

***ENDOCRINE***

Swollen glands in the neck Groin lymph node swelling Excessive thirst Temperature intolerance

Breast pain Nipple inverted Breast reddening Breast swelling Nipple discharge Asymmetrical

***SKIN***

Rashes Itching

Recurrent skin infections

***HEMATOLOGICAL***

Easy bruising Bleeding problem

***No Current Symptoms***

Signature of Patient/Patient Representative: Date signed: