Salem Plastic Surgery, Inc.

PATIENT INTRODUCTION

PLEASE COMPLETE AND RETURN TO THE RECEPTIONIST WITH YOUR INSURANCE CARD(S)

(Please Print)

Today's Date: _____

Referring Physician: _____

Family Physician: _____

How did you hear about our practice? _____

PATIENT INFORMATION

Patient's Name: _____ _____ _____
(First) (Middle/Maiden) (Last)

Date of Birth: _____ Age: _____ ☐Male ☐Female Social Security Number: _____

SOCIAL IDENTIFICATION

Marital Status: ☐ Single ☐ Widowed ☐ Separated ☐ Divorced ☐ Married

If married, Spouse's Name: _____ Spouse's DOB: _____

Ethnicity: ☐ Not of Hispanic Origin ☐ Hispanic ☐ Refused ☐ Unknown

Race: ☐ Black/African American ☐ Hispanic/Latino ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Refused ☐Other

Religion: _____

PHARMACY INFORMATION

Name: _____ Location: _____

Address: _____
and Street/ Route and Box # City State Zip

Phone #: _____ Fax#: _____

CONTACT INFORMATION

Present Address: _____
and Street/ Route and Box # City State Zip

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____ Consent to Text: (Please circle) YES or NO Carrier: _____

EMPLOYER ADDRESS

Employer: _____

Address: _____
and Street/Route and Box # City State Zip

Business Phone: _____ Consent to call: (please circle) YES or NO Job: _____

EMERGENCY CONTACT

Relationship to Patient: _____

Name: _____ _____ _____
(First) (Middle/Maiden) (Last)

Address: _____
and Street/Route and Box # City State Zip

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

CONSENT TO COMMUNICATE

If it's OK to leave a message with another person, please list them:

Name	DOB	Relationship	Contact number	OK to release results
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

INSURANCE INFORMATION

Please present cards to receptionist

Do you have Medicare? ☐Yes ☐No Do you have Medicaid? ☐Yes ☐No

Insurance (1) _____ Insurance (2) _____

Policy # _____ Policy # _____

Group # _____ Group # _____

Effective Date: _____ Effective Date: _____

Worker's Comp Claim: ☐Yes ☐No
If yes, name of carrier: _____

Phone number for carrier: _____ Contact Person: _____

Address: _____
and Street/Route and Box # City State Zip

Salem Plastic Surgery, Inc.

DATE: _____

MEDICAL HISTORY FORM

NAME:_____

DATE OF BIRTH: _____ AGE: _____

CHIEF COMPLAINT/PROBLEM: _____ HEIGHT: _____ WEIGHT: _____

Section I: Surgery and Anesthesia History

1. Have you ever had surgery, or hospitalization? ☐ No ☐ Yes, please describe:

   _____

   _____

2. Did you experience problems resulting from anesthesia administered to you? ☐ No ☐ Yes, please describe:

   _____

   _____

3. Have you ever been told by a medical professional that they had a difficult time intubating you before surgery?

   ☐ No ☐ Yes, please describe:_____

   _____

4. How many times have you had anesthesia for surgery in the past? _____

   Date of last general anesthesia _____

5. Do you have a blood relative who had anesthesia complications of any kind? ☐ No ☐ Yes, please describe:

   _____

   _____

Section II: Specific Medical History

1. Are you pregnant? ☐ No ☐ Yes Due Date: _____
2. Children? ☐ No ☐ Yes Ages: _____
3. Date of last menstrual cycle: _____
4. Date of last pap smear: _____
5. Date of last mammogram: _____ Location: _____

Please assist us with developing an accurate medical history for you by answering the following questions.

Do you presently have or have you ever in the past had any of the following medical conditions?
Simply check the appropriate "NO" or "YES" space. Add comments if necessary.

LUNGS	**NO**	**YES**	**COMMENTS**
Pneumonia	☐ No	☐ Yes	
Asthma	☐ No	☐ Yes	
Born with any lung disease	☐ No	☐ Yes	
Cough or cold (presently)	☐ No	☐ Yes	
Bronchitis	☐ No	☐ Yes	
Emphysema	☐ No	☐ Yes	
Positive TB test	☐ No	☐ Yes	
If YES, have you had BCG vaccine	☐ No	☐ Yes	
Treated for TB	☐ No	☐ Yes	
Sleep Apnea	☐ No	☐ Yes	
HEART			
Born with any heart disease	☐ No	☐ Yes	
Heart murmur	☐ No	☐ Yes	
Rheumatic fever	☐ No	☐ Yes	

High blood pressure ☐ No ☐ Yes _____
Skipped heart beats ☐ No ☐ Yes _____
Chest pains ☐ No ☐ Yes _____
Hardening of the arteries ☐ No ☐ Yes _____
Heart failure ☐ No ☐ Yes _____
Heart attacks ☐ No ☐ Yes _____
Do you have pacemaker/defibrillator? ☐ No ☐ Yes _____

BLOOD

Sickle cell trait or disease ☐ No ☐ Yes _____
Other disease of blood cells ☐ No ☐ Yes _____
Abnormal blood clotting ☐ No ☐ Yes _____

LIVER

Infectious disease, such as
Hepatitis, HIV, etc. ☐ No ☐ Yes _____
Jaundice ☐ No ☐ Yes _____
Other liver disease ☐ No ☐ Yes _____

GASTROINTESTINAL

Reflux ☐ No ☐ Yes _____
Irritable bowel syndrome ☐ No ☐ Yes _____
Hiatal hernia ☐ No ☐ Yes _____

KIDNEY

Born with kidney disease ☐ No ☐ Yes _____
Kidney infections ☐ No ☐ Yes _____
Kidney stones ☐ No ☐ Yes _____
Kidney failure ☐ No ☐ Yes _____
Urinary tract infections ☐ No ☐ Yes _____

NERVOUS SYSTEM

Born with NV system abnormality ☐ No ☐ Yes _____
Brain disease ☐ No ☐ Yes _____
Spinal cord disease ☐ No ☐ Yes _____
Migraines ☐ No ☐ Yes _____
Nerve disease ☐ No ☐ Yes _____
Epilepsy ☐ No ☐ Yes _____
Stroke ☐ No ☐ Yes _____
Seizures ☐ No ☐ Yes _____
Depression ☐ No ☐ Yes _____

ENDOCRINE

Diabetes ☐ No ☐ Yes _____
Thyroid disease ☐ No ☐ Yes _____

EYE

Glaucoma ☐ No ☐ Yes _____
Wear contact lenses ☐ No ☐ Yes _____

DENTAL

Bridges, crowns, dentures ☐ No ☐ Yes _____
Loose teeth ☐ No ☐ Yes _____

Infection/Non-healing wound

C-Diff
(Clostridium Difficile bacterial infection) ☐ No ☐ Yes _____
VRE
(Vancomycin resistant enterocci) ☐ No ☐ Yes _____
MRSA
(Methicillin resistant staphylococcus aureus) ☐ No ☐ Yes _____
Non healing wounds ☐ No ☐ Yes _____

OTHER

Problem scarring	☐ No	☐ Yes	_____
Mental Health	☐ No	☐ Yes	_____
Gout	☐ No	☐ Yes	_____
Arthritis	☐ No	☐ Yes	_____

Personal history of carcinoma (cancer)? ☐ No ☐ Yes, describe _____
History of Injury? ☐ No ☐ Yes, describe _____
Are you being treated for any other conditions not listed? ☐ No ☐ Yes, describe _____
_____

Section III: Medications

1. Are you taking any medications, vitamins, or herbal supplements? ☐ No ☐Yes, please describe
   _____
   _____

Section IV: Allergies and Sensitivities

1. Are you allergic to any medications, food, latex, local anesthesia? ☐ No ☐Yes, please describe:
   _____

Section V: Social History

1. Do you smoke? ☐ No ☐ Yes, how much? _____
2. Do you drink? ☐ No ☐ Yes, how much? _____
3. Have you ever taken recreational drugs? ☐ No ☐ Yes
4. Have you ever taken steroids (i.e. cortisone or prednisone)? ☐ No ☐ Yes

Section VI: Family History

Have any blood relatives have or ever had in the past had any of the following medical conditions?
Simply check the appropriate "NO" or "YES" space. Add comments if necessary.

	NO	YES	COMMENTS
Cancer	☐ No	☐ Yes	_____
Bleeding tendency	☐ No	☐ Yes	_____
Leukemia	☐ No	☐ Yes	_____
Heart Disease	☐ No	☐ Yes	_____
High Blood Pressure	☐ No	☐ Yes	_____
Repeated Infections	☐ No	☐ Yes	_____
Chronic Lung Disease	☐ No	☐ Yes	_____
Tuberculosis	☐ No	☐ Yes	_____
Asthma	☐ No	☐ Yes	_____
Severe Allergies	☐ No	☐ Yes	_____
Kidney Disease	☐ No	☐ Yes	_____
Arthritis	☐ No	☐ Yes	_____
Mental Illness	☐ No	☐ Yes	_____
Convulsions or Fits	☐ No	☐ Yes	_____
Migraine Headaches	☐ No	☐ Yes	_____
Diabetes	☐ No	☐ Yes	_____
Gout	☐ No	☐ Yes	_____
Thyroid Trouble	☐ No	☐ Yes	_____
Obesity	☐ No	☐ Yes	_____

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

_____ _____
PATIENT SIGNATURE **DATE**

HIPAA Information and Consent Form

Patient Name: _____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

10. I give permission to Salem Plastic Surgery to share my Health information with:

_____/_____/_____

I, _____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____